Integrated Health Project in Burundi

Contract No: AID-623-C-14-00001

YEAR 4 ANNUAL REPORT

October 1, 2016 - September 30, 2017

Submitted by FHI 360

Submission date: October 31, 2017

USAID
FROM THE AMERICAN PEOPLE

Table of contents

List of tables

List of figures

Acronyms and Abbreviations

ACT	Artemisinin-Based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BDS	District Health Bureau (*Fr. Bureau du District Sanitaire*)
BEmOC	Basic Emergency Obstetric and Newborn Care
BMCHP	Burundi Maternal and Child Health Project
BPS	Provincial Health Bureau (*Fr. Bureau Provincial de Santé*)
BRAVI	Burundians Responding Against Violence and Inequality
CBD	Community-Based Distribution
CBO	Community-Based Organization
CCA	Clinical and Community Action
CCM	Community Case Management
CCT	Community Conversation Toolkit
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHW	Community Health Worker (*Fr. APS*)
C-IMCI	Community-based Integrated Management of Childhood Illness
COP	Chief of Party
COSA	Community Health Committee (*Fr. Comité de Santé*)
CPA	Complementary Package of Activities
CPVV	Provincial Verification and Validation Committee *(Fr. Comité Provincial de Vérification et de Validation*)
CS	Capacity Strengthening
CSO	Civil Society Organization
CTN	*Fr. Cellule Technique Nationale*
DCOP	Deputy Chief of Party
DHIS	District Health Information System
DHT	District Health Team
DPSHA	Department of Health, Hygiene and Sanitation Promotion
ENA	Essential Nutrition Actions
EOP	End of Project
FAB	Formative Analysis and Baseline Assessment
FOG	Fixed Obligation Grant
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender Based Violence
GOB	Government of Burundi
GUC	Grant Under Contract
HBC	Home-Based Care
HC	Health Center
HHS	Household Survey
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Technician
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
IHPB	Integrated Health Project in Burundi
IKG	In Kind Grant
IMCI	Integrated Management of Childhood Illnesses
IP	Implementing Partner
IPC	Interpersonal Communication
IPTp	Intermittent Preventive Treatment in Pregnancy
ITN	Insecticide-Treated Net (MIILDA)
IYCF	Infant and Young Child Feeding
LOE	Level of Effort
LOP	Life of Project
LPT	Local Partner Transition
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MPA	Minimum Package of Activities
MPHFA	Ministry of Public Health and the Fight against AIDS
MR	Mandatory Results
MSM	Men Who Have Sex sith Men
NGO	Non-Governmental Organization
NHIS	National Health Information System
NPAC	National Program for AIDS/STIs Control
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMEP	Performance Monitoring & Evaluation Plan
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Post-Natal Care
PPP	Public-Private Partnership
Q1, Q2, etc.	First Quarter, second quarter, etc.
QA	Quality Assurance
QI	Quality Improvement
RDT	Rapid Diagnostic Tool
RH	Reproductive Health
ROADS II	Roads to a Healthy Future II Project
SARA	Service Availability and Readiness Assessment
SBC	Social and Behavior Change
SBCC	Social and Behavior Change Communication
SCM	Supply Chain Management
SDP	Service Delivery Point
SLT	Senior Leadership Team
SOP	Standard Operating Procedure
STG	Standard Grant
STI	Sexually Transmitted Infection
STA	Senior Technical Advisor
STO	Senior Technical Officer
STTA	Short-Term Technical Assistance
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government
Y1, Y2, etc.	Project Year One, Project Year Two, etc.
YFS	Youth Friendly Service

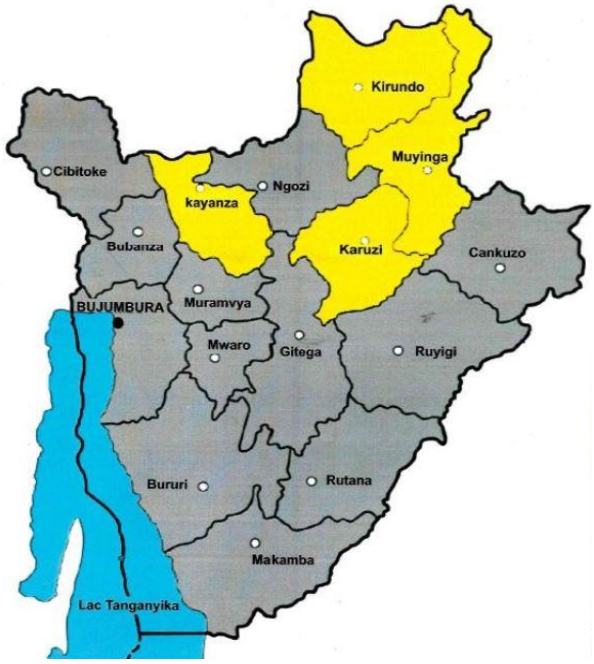
Introduction & Summary of Results

The *Integrated Health Project in Burundi* (IHPB) is a five-year project (December 23, 2013 to December 22, 2018) funded by the United States Agency for International Development (USAID). IHPB builds on USAID's legacy of support to the health sector in Burundi and FHI 360 and Pathfinder International's successes in assisting the Government of Burundi (GoB) to expand and integrate essential services for HIV/AIDS; maternal, neonatal and child health (MNCH); malaria; family planning (FP); and reproductive health (RH).

The Ministry of Public Health and Fight against AIDS (MPHFA) is a major partner that is involved at every step throughout project planning and implementation. IHPB's goal is to assist the GoB, communities, and civil society organizations (CSOs) to improve the health status of populations in 12 health districts (HDs) located in the provinces of Karusi, Kayanza, Kirundo, and Muyinga. IHPB's expected results are:

1) Increased positive behaviors at the individual and household levels;
2) Increased use of quality integrated health and support services; and
3) Strengthened health system and civil society capacity.

This annual performance report provides information on the results and accomplishments of the IHPB for the period October 1, 2016 through September 30, 2017.



Year 4 Achievements - Targets and Results: IHPB made significant progress with regards to reaching its Year 4 targets noted in the project's Performance Monitoring and Evaluation Plan (PMEP). Annex I presents Year 4 achievements against targets. *The following summarizes the main results under each Sub-CLIN:*

For the four Sub-CLIN 1.1 (i*mproved key behavioral pre-determinants at individual, household and community levels),* the achievement of mandatory results will be measured through the end of project survey planned for in Y5. However, for indicator 1.1.4 (*number of health communication materials developed, field-tested, and disseminated for use*), IHPB has achieved the Y4 target of eight.

For the three Sub-CLIN 1.2 (*Increased accessibility and availability of health products to individuals and households*) indicators, whose performance depends on availability of drugs at the Central Medical Stores, CAMEB) achievements *to reduce the proportion of sites with stock outs of contraceptives* (from 38% baseline to 10% in Y4) *and increase the proportion of health centers that meet minimum SCM standards* (from 49% at baseline to 88% in Y4) were mixed. However, for the mandatory indicator*, reduce the proportion of supported facilities that experience a stock out during a quarter* (to < 50% in Y4), the life of project target (52%) has been achieved (45%).

Sub-CLIN 1.3 (*strengthened support for positive gender norms and behaviors and increased access to GBV services):* For indicator 1.3.1 (*number of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalance within the household*), IHPB exceeded its Y4 target of five by implementing 12 interventions. For indicator 1.3.2 (*Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services),* by establishing comprehensive GBV programs (medical, psychosocial, legal and community care) in Buhiga and Nyabikere health districts, IHPB achieved 50% of its Y4 target of 4 districts. For indicator 1.3.4 (*Number of people receiving post-GBV care (post-rape care, other post-GBV care, PEP*), in Y4 October – August, IHPB exceeded its Y4 target of 110 through the support to 130 survivors of GBV.

Sub-CLIN 2.1: For indicator 2.1.1 (*Percent of supported health centers with CHWs that provide core package of quality integrated health and support services),* IHPB made progress from zero at baseline to 36% at mid-term – life of project target of 40% will be assessed in Y5. For indicator 2.1.2 (*Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women*), IHPB exceeded its target of 80,000 by achieving 164,380 visits, mainly due to the malaria epidemic.

For Sub-CLIN 2.2: Through a combination of competency-based trainings and quality improvement (QI) activities, the mid-term survey revealed that the *percentage of facilities that provide a core/expanded package of quality integrated health services has increased significantly from baseline, already exceeding the LOP target*. The *percentage of facilities that perform to national technical and quality standards* has reached 75%, achieving its Y4 target

In Y4, IHPB has achieved or is on track to complete the targets set for human resources for health (HRH) indicators by the end of the project. For Sub-CLIN 2.3.1 (*Percent of project trained health providers, managers and CHWs who perform to a defined standard post-training*), the Y4 target was set at 95% and IPHB reached 97.4%. For Sub-CLIN 2.3.2 (*Percent of supported health providers, managers and CHWs who demonstrated improvement post-training),* IHPB achieved 94.6%, well above the fixed target of 90%. For 2.3.3 (*Percent of trained health care staff who report positive attitudes (composite indicator) about work and the work place),* the initial target of 66% was largely exceeded – the mid-term evaluation rated it at 79.2%.

For Sub-CLIN 3.1.1 (*Percent of supported facilities that have available all current national health policies, protocols, and guidelines),* IHPB continues its annual improvement trend and all targets have been achieved except for the documents related to maternal health and malaria services as health workers take these documents when they are transferred to another post. For Sub-CLIN 3.1.2 (*Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services*), the Y4 target remains at 51.1% having increased significantly from 26.6% at baseline due to the equipment supplied by the IHPB in Y2. For Sub-CLIN 2.2.4 (*Percent of supported facilities that receive supportive supervision on a regular basis),* 82% (out of a target of 100%) received supportive supervision during the fourth year. The *percent of supported districts and provinces that conduct planning and resources mobilization* (Sub-CLIN 3.1.5) remains at 100% as IHPB provides financial and technical support for the conduct of quarterly coordination and data analysis meetings and annual planning.

For the two indicators of Sub-CLIN 3.2, *percent of facilities that maintain timely reporting (3.2.1) and percent of districts and facilities that demonstrably use facility and community-level data for timely decision making (3.2.2),* quarterly improvements in timely reporting and data quality continued throughout Y4. For 3.2.1, the achievement rate was 93% (915/97.8%). For 3.2.2, the achievement rates are as follows: 99% (94%/95%) for facility and 99% (89%/90%) for districts.

Having achieved the results related to the indicators 3.3.1 *(Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas);* 3.3.2 *(Number of CSOs that transition (graduate) and qualify to receive direct USAID funding);* and 3.3.5 *(Number of CSOs that improved their organizational capacity with USG assistance)* in Y3, in Y4, IHPB CSO activities focused on monitoring implementation of the ANSS sub-grant - regular supervisions were conducted, focused on organizational and technical activities.

In Y4, the HIV/AIDS, maternal and neonatal (MNH), malaria, child health (CH) and family planning and reproductive health (FP/RH) strategies and interventions led to solid progress (often exceeding Y4 targets) on respective PEPFAR, malaria, MNH, CH and FP/RH indicators as detailed in the annual report. This is attributable, in large part, to the existence of competent MPHFA trainers and supervisors; to implementing HIV activities within UNAIDS 90-90-90 strategy and PEPFAR 3.0 priorities targeting two provinces with high HIV burden and seroprevalence (Kayanza and Kirundo); to the quick implementation of active management of the third stage of labor (AMTSL); to training of community health workers on community based distribution (CBD) of contraceptives; to training of health workers on vasectomy; and by a combination of

activities supported by the project that include training, supervision and all the activities described under each Sub-CLIN. The achievements and results registered in Y4 can also be attributed to the excellent working relationship with the central and peripheral structures of Ministry of Public Health and the Fight against AIDS (MPHFA) and the strong support IHPB received from the various MPHFA technical programs.

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels

CLIN 1 includes IHPB's activities in SBCC (Sub-CLIN 1.1), supply chain management (SCM) (Sub-CLIN 1.2), and gender integration and GBV service strengthening (Sub-CLIN 1.3). Table below presents major Sub-CLIN 1.1, 1.2, 1.3a and 1.3b Y4 activities.

Sub – CLIN	Major Y4 activities
Sub-CLIN 1.1 Improved key behavioral pre-determinants at the individual, household and community levels	• Completed a range of SBCC tools and trainings per project's SBCC strategy • Finalized Inter Personal Communication Module designed to equip MPHFA staff with state-of-the-art and evidence-based skills to promote behavior change • 63 health promotion technicians (HPTs) trained as master trainers for the Pregnant Women life stage • Produced a six-episode radio drama and 12 public service announcements (PSAs) • Drama was broadcast 5 times and the PSA 30 times each on 4 radio stations
Sub-CLIN 1.2 Increased accessibility and availability of health products to individuals and households	• Provided refresher training course on facility quantification, stock management and inventory methods to 24 pharmacy staff (Vumbi) • Developed and piloted SCM module of *Outil d'Amélioration des Services Integrés de Santé* (OASIS) • Facilitated transport distribution of health commodities in intervention provinces - trucks have been rented in response to gaps in vehicle availability at district level 100 times
Sub-CLIN 1.3a Promote gender integration and transformation across project activities	• Trained community members and began implementing Men-as-Partner (MAP) program in collaboration with Engender Health • Continued integrating gender into SBCC mass media activities • Built 21 IHPB staff and 6 Karusi district staff on gender integration training

Sub – CLIN	Major Y4 activities
	• IHPB and LINKAGES projects collaborated to plan a stigma reduction strategy for providers serving female sex workers (FSW) and men who have sex with men (MSM)
Sub CLIN 1.3b Strengthened support for positive gender norms and behaviors and increasing access to GBV services	• Trained 20 trainers (five per province) on the integrated management of GBV survivors. Trainers trained 86 health care providers • Trained 75 providers on listening and psychological support skills • Mapped the GBV landscape in IHPB intervention provinces • Supported 2 GBV stakeholder coordination meetings (in Buhiga and Nyabikere)

Y4 Progress and Discussion on Sub-CLIN 1.1 *(Improved key behavioral pre-determinants at the individual, household and community levels*) Result Indicators

Table 1: Y4 Progress and Discussion on Sub-CLIN 1.1

Indicator	Target FY 2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4	Total
1.0.1. Percent of the targeted audiences who report practicing positive behaviors at the individual and household levels	N/A	The Outcomes indicators will be measured through the end of project survey, planned in Y5				
1.1.1. Percent of the targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels	N/A					
1.1.2. Percent of targeted population who correctly report causes of specific illness (e.g. HIV/AIDS; malaria; diarrhea)	N/A					
1.1.3. Percent of the target population who recall hearing or seeing or reading a specific health communication message	N/A					
1.1.4 Number of health communication materials developed, field tested, and disseminated for use	8	0	5	3	0	8

For the four Sub-CLIN 1.1 (*Improved key behavioral pre-determinants at individual, household and community levels)* outcome indicators (1.0.1, 1.1.1, 1.1.2 and 1.1.3), progress will be measured through the end of project survey planned for in Y5. Activities implemented in Y4 for attainment of the aforementioned indicators are presented below:

- IHPB developed an interpersonal communication module that covers the first two life stages (pregnant women and parents with children under five). 63 health promotion technicians (HPTs) were trained as master trainers for the Pregnant Women life stage, who, in turn, trained all 3,288 community health workers (CHWs) with a focus on (SDAs). Practice scenarios were used to engage men to play a more supportive role for their pregnant spouses. The same process for the life stage, Families with Children under 5, was followed and 63 HPTs and 3,288 CHWs were trained. By August, CHWs had conducted 47,867 home visits to pregnant women and their partners.
- IHPB, in collaboration with the Karusi health province, identified six families in the Gihogazi commune who had achieved the nine key actions for pregnant women and delivered certificates of merit before an audience of 300. These model families shared their testimonies on how they negotiated obstacles to successfully carry out the nine key actions.
- IHPB produced 3 trigger videos each targeting a different life stage: i) Melissa with key messages on maternal new born and child health; ii) Fidelité targeting young adult with key messages on

Sexual Reproductive Health and HIV/AIDS; and iii) Temptation targeting adolescents with key messages on HIV/AIDS and sexual and Reproductive Health.

- 22 mobile cinema sessions were conducted on diverse health issues with a focus on malaria prevention during the epidemic. The 22 sessions, carried out in all the 12 Health Districts, reached an estimated 17, 234 people.
- The 6 radio dramas produced by PCI Media Impact were broadcasted 2 times on radio Isanganiro and radio Umuco. Each drama episode was followed by a call-in show whereby a studio host invited listeners to ask question while engaging the audience in a dialogue around the health issues presented in the drama. As an example, the radio drama, KIRA MAMA, was broadcasted as part of a local call-in show to influence knowledge and attitudes around an integrated set of health issues for pregnant women.
- With the objective to reach as much an audience as possible, IHPB strategically decided to re-broadcast (KIRA MAMA Radio drama) and extend the number of radio stations. It was therefore, rebroadcasted 4 times by the National radio station (RTNB), Radio Isanganiro, REMA FM and the local radio station UMUCO FM. Each of the 12 Public services announcements has been running on the aforementioned radio stations for 30 times during a period of 60 days. The 4 radio stations IHPB used constitute 80 % of audience exposures and reach over 397,000 households in the 4 provinces.
- In close partnership with the Ministry of Health's IEC department produced 22 radio programs and 11 public service announcements. The programs were broadcasted to a national audience and were aired for free by the National Radio. The two programs are titled "Irondoka rijanye n'amagara meza" and "Intungamagara".

1.1.4 Number of health communication materials developed, field tested, and disseminated for use

In Y4, achieving the target, 8 communication materials were developed, field tested and disseminated: five for parents of children under five - 2 posters, 1 flipchart, 1 invitation card and 1 leaflet. In response to a request from the malaria epidemic subcommittee, IHPB developed, field tested and distributed three communication materials: a flip chart that covers LLIN use, malaria symptoms, full medicine uptake, prompt care seeking, washing and repair nets and vector control options for malaria prevention and 2 posters that focus on the proper hanging, repair and washing of the mosquito nets.

Y4 Progress and Discussion on Sub-CLIN 1.2 (*increased accessibility and availability of health products to individuals and households*) Result Indicators

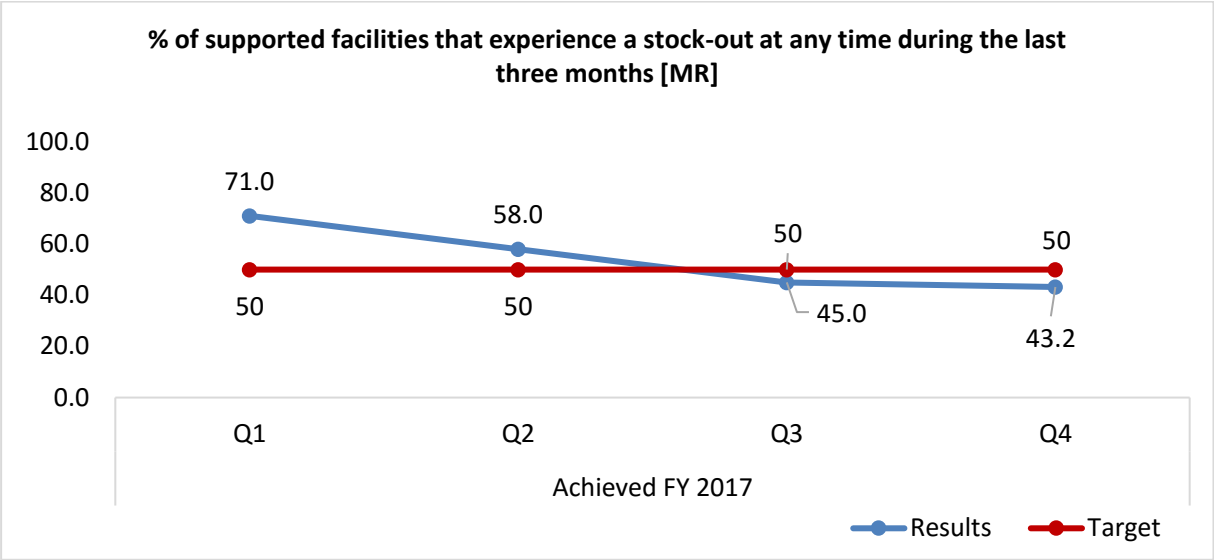
Table 2: Y4 Progress and Discussion on Sub-CLIN 1.2

Indicator	Target FY2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4	Total
1.2.1. Percent of supported facilities that experience a stock-out at any time during the last three months (Data Source: DHIS2)	50%	71%	58%	45%	43.2%[1]	
1.2.2. Percent of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptive method that the SDP is expected to provide at any time during the reporting period (Data Source: Monthly Contraceptive Methods District Report:	10%	3.4%	10.7%	22%	10.9	9.5
1.2.3. Percent of health centers that meet minimum SCM standards (Data Source: PBF database)	88%	Annual Indicator (Data not available)				

[1] Data for July and August

1.2.1 Percent of supported facilities that experience a stock-out at any time during the last three months

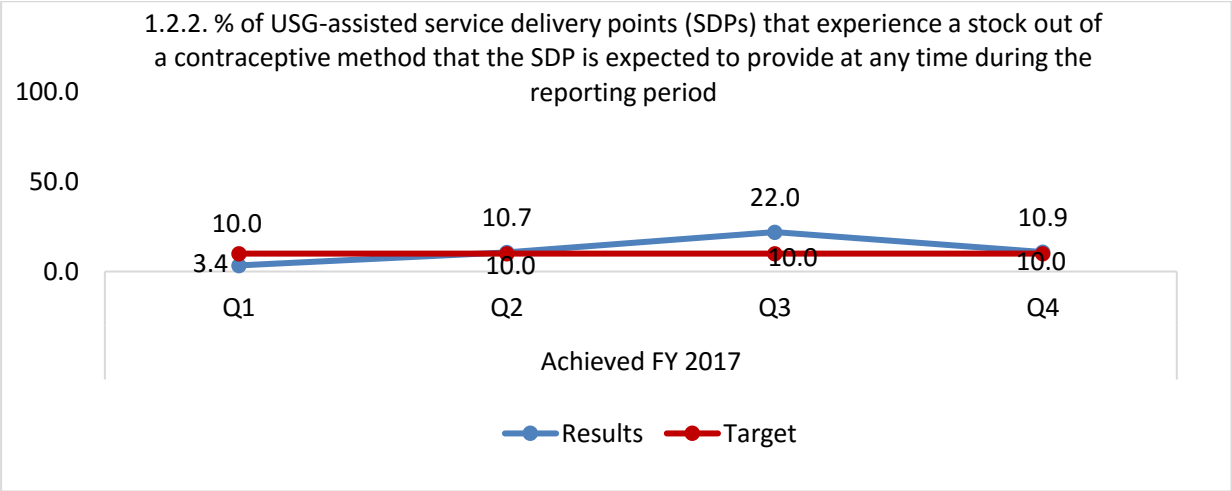
Figure 1: Percent of supported facilities that experience a stock-out at any time during the last three months



The Y4 target of 50% was not achieved for the 22 tracer products[2] reported by the project during the first and second quarters due to stock outs of some essentials commodities at the central warehouse, Drugs most frequently stocked out were Mebendazol (100 mg), Oxytocin, Quinine (500 mg) and ORS. Busoni, Mukenke, Giteranyi and Gashoho HDs experienced the most frequent stock-outs. The decreasing trend in t the magnitude of stock-outs is the result of the project interventions at district and facility levels, specifically oriented towards pharmacy stock management and monitoring of average monthly consumptions for tracers' drugs.

1.2.2 Percent of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptives method that the SDP is expected to provide at any time during the reporting period

Figure 2: Percent of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptives method that the SDP is expected to provide at any time during the reporting period



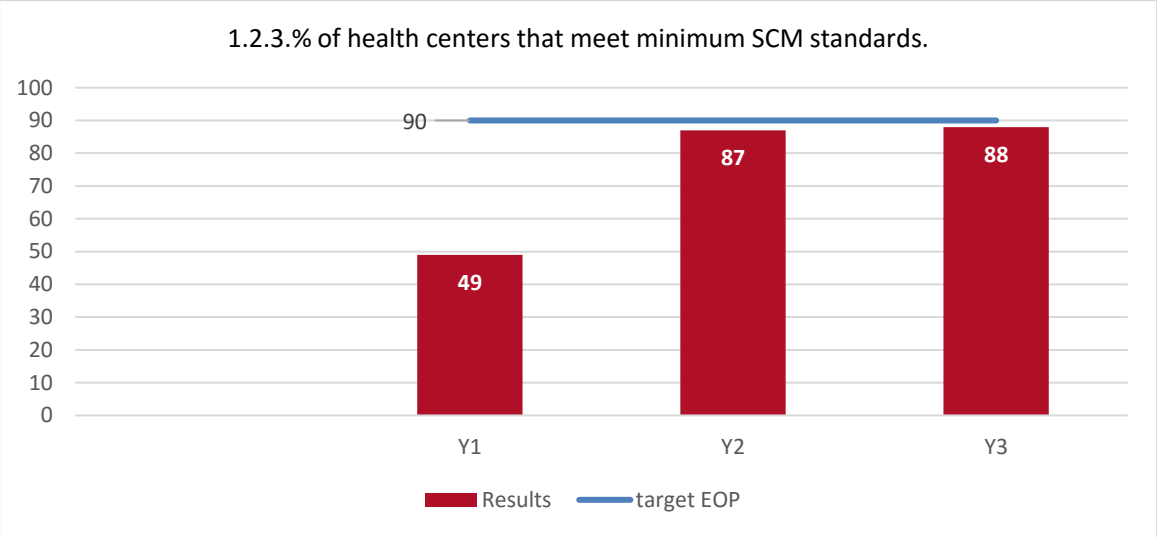
The variations in stocks-outs are due mainly to the lack of commodities at health district level, which results in facility-level stock outs. In Q3, we observed a higher consumption of oral contraceptives, injectables and

[2] Tracer products: albendazole (400mg), amoxycillin (500mg), ACT 2-11 months, ACT 1-5 yrs, ACT 6-13 yrs, ACT +14 yrs, chlorhexidine, cotrimoxazole (480 mg), folic acid, aluminum hydroxide, indomethacin, mebendazole, oxytocin, metronidazol, paracetamol, penicillin tablet, quinine 500 mg, serum glucose, ORS, malaria RT, HIV test, pentavalent.

(IUD) compared to other quarters. This is confirmed by the observed increase in couple years protection in the second quarter from 45.216 (29%) to 60.108 (39%)

1.2.3 Percent of health centers that meet minimum SCM standards

Figure 3: Percent of health centers that meet minimum SCM standards



Sub-CLIN 1.3: Strengthened support for gender norms and behaviors and increased access to GBV services

Y4 Progress and Discussion on Sub-CLIN 1.3a (*Promote gender integration and transformation across project activities*) Result Indicators

Table 3: Y4 Progress and Discussion on Sub-CLIN 1.3a

Indicator	Target FY 2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4	Total
1.3.1 Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household).	5	2	6	2	2	12

1.3.1 Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household)

The Y4 target of 5 project interventions that address at least one gender theme has been surpassed. The table below summarizes the 12 gender interventions and their respective theme(s).

Table 4: Number of project interventions that address at least one gender theme

Activities/Interventions	Gender theme			
	Male norms	Gender-based violence	Service equity	Power imbalances within the household
Developed 12 messages with elements of gender equity (aired in December 2016 on Isanganiro and Umuco FM radio stations) [One intervention]			✓	✓
Conducted two awareness raising workshops on GBV in Karusi and Kirundo provinces [One intervention]		✓		
Conducted three separate training of trainer sessions on Men as Partners (MAP), Gender Based Violence and reduce gender-based stigma toward	✓	✓	✓	

Activities/Interventions	Gender theme			
	Male norms	Gender-based violence	Service equity	Power imbalances within the household
men who have sex with men (MSM) and female sex workers (FSW) [Three interventions]				
Organized two training sessions (one on gender integration and another on GBV case management [Two interventions]	✓	✓		✓
Organized one mobilization meeting on men's involvement in family planning [One intervention]	✓		✓	✓
Conducted 18 training sessions to 517 CHWs on the MAP [One intervention]	✓		✓	✓
Conducted 18 training sessions to 517 CHWs on the community GBV management [One intervention]		✓		
Organized one training session on psychological support for GBV victims [One intervention]		✓		
Held one mobilization meeting on gender equity and community GBV prevention and management. [One intervention]	✓	✓	✓	✓

Those interventions contribute also to other indicators especially 1.3.2 (*Percent of supported health districts that have at least one comprehensive GBV program and at least on male involvement initiative with referrals to health services and products*), indirectly 1.0.1 (*percent of targeted audiences who report practicing positive behaviors at the individual and household levels*) and 1.3.3 *(percent of population reporting agreement with the concept that males and females should have equal access to social, economic and political opportunities*) that are project outcomes.

IHPB's gender equality work has focused on engaging community members and men in particular. In addition, the community package for GBV victims discusses how to engage husbands to support reproductive health and their attendance at their partner's ANC visits and support during childbirth. IHPB in partnership with MPHFA IEC Unit and the PSNR developed a community sensitization tool to support the MAP community module and GBV package to victims.

Y4 Progress and Discussion on Sub-CLIN 1.3b (*Strengthened support for positive gender norms and behaviors and increasing access to GBV services*) Result Indicators

Table 5: Y4 Progress and Discussion on Sub-CLIN 1.3b

Indicator	Target FY2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4	Total
1.3.2. Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services	33% (4/12)	N/A[3]	N/A	N/A	N/A	17% (2/12)
1.3.4. Number of people receiving post-GBV care (post-rape care, other post-GBV care, PEP)	110	44	24	22	40[4]	130
1.3.5. Number of facilities that provide PEP to GBV survivors	34	30	31	32	37[5]	37

[3] Indicator reported on annually.
[4] Data for September not available
[5] Data for September not included

Indicator	Target FY2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4	Total
Number of people trained on GBV case management (Trainers, health care providers, and CHWs)	627	0	65	560	75	700

During Y4, IHPB continued to improve the programming for SGBV in its intervention provinces. IHPB assisted national and district teams to provide comprehensive services to SGBV survivors. The project contributed to the availability of quality services and increased the conditions for SGBV survivors to access the full package of available services.

1.3.2 Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products

"Comprehensive GBV program" refers to interventions and services provided to survivors of GBV, including health, social, and legal services through referrals (referrals to services other than those available). "Male involvement initiative" refers to interventions that are aimed at any one of the following: sexual and reproductive health communication targeted at young men, involvement of men in FP/RH decision-making, attendance of men at their partner's ANC visits, attendance of men at the facility during the birth of their child, etc.

During Y4, IHPB achieved 50% of its target (4), establishing a comprehensive GBV program (medical, psychosocial, legal and community care) and at least one male involvement initiative in Buhiga and Nyabikere health districts.

IHPB focused on activities aimed at the overall management of GBV and male involvement in Buhiga and Nyabikere health districts of Karusi province by:

- Training five trainers on the integrated management of GBV survivors;
- Training 75 providers on listening techniques and psychological treatment and initiated these services in 37 health facilities;
- Partnering with the Centre de Développement Familial et Communautaire (CDFC) to conduct GBV community awareness events and establishing seven GBV Joint Committees set up quarterly objectives and plans to achieve them;
- Training 517 CHWs on gender-equality integration by engaging communities, especially men through Men as Partners (MAP), and community-level comprehensive package for GBV survivors.
- Partnering with MPHFA IEC unit and PNSR, IHPB developed a community sensitization tool in Kirundi for CHWs to support the mainstreaming of gender equality by engaging men and promoting community care for GBV survivors. This tool has already implemented in two HD (Buhiga and Nyabikere) and we plan to use it in the health districts of Kayanza, Gahombo, Kirundo and Vumbi during Y5
- Conducting a SGBV landscape mapping exercise in the 4 provinces: interviewed 56 HF staff; 43 community leaders; 3 prosecutors' offices; 4 district courts; 3 judicial police stations; 3 CDFC and 3 CSOs that provide psychosocial services to victims of SGBV.

The key findings of the SGBV landscape mapping are:

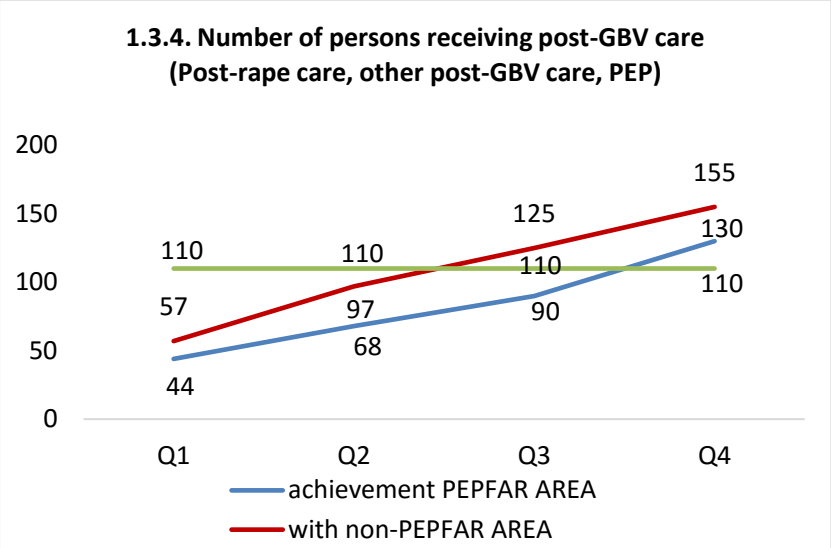
- While many GBV survivors are poor, some care services (pregnancy tests, antibiotics, consultations) that a GBV survivor needs are only available for a service fee, limiting access to these services for many survivors;
- Insufficient number of staff trained to provide medical, psychological and legal care for survivors of GBV;
- Lack of psychosocial care for GBV survivors;
- Lack of monitoring tools to manage GBV survivor care (clinical records, survivor follow-up records, confidential registers, national protocol of care, drawers or locked cabinets) and lack of infrastructure to keep the survivors' files in a private, confidential location;

- Of the 56 HFs considered, 46 HF have ARVs but only 29 HF offer post-exposure prophylaxis for GBV victims;
- Unavailability of hepatitis B vaccine, and few health facilities offer survivors of GBV tetanus vaccine;
- Unavailability of infrastructures that can ensure the confidentiality and safety of GBV survivors seeking services;
- The community is unaware of the services offered by CFDCs and other institutions that provide psychosocial services to survivors of GBV;
- The survivors of GBV do not denounce the perpetrators because of intimidation and social pressure, as well as the attitudes of local political leaders and authorities.

Building upon the solid foundation laid in Y4 and experience gained so far, IHPB will expand the GBV program and the male involvement initiative to an additional four health districts (budget permitting) in Y5 to reach the target of 6 health districts required by end of project.

1.3.4 *Number of people receiving post-GBV care (post-rape care, other post-GBV care, PEP)*

Figure 4: Number of people receiving post-GBV care (post-rape care, othe



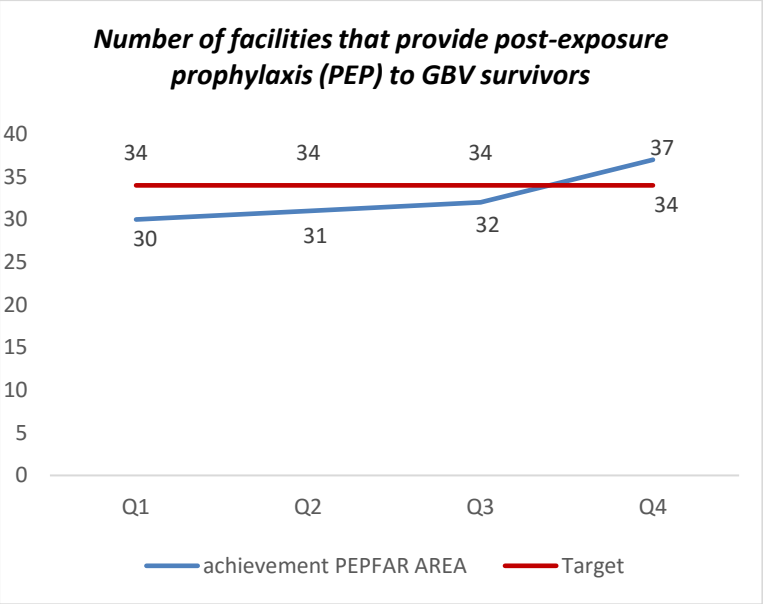
In Y4, during the period October 2016 – July 2017, 130 survivors (representing 118% of Y4 target) received post-GBV care in the two PEPFAR provinces. Including the 25 survivors who received post-GBV care in the non-PEPFAR area, 155 people received post-GBV care. This represents 141% of the Y4 target.

IHPB initiated activities to stimulate the community to seek services in health facilities when needed. During Y4, IHPB has focused on activities such as:

- Training CHWs on community care of GBV survivors. The referral of GBV survivors to care facilities is the most important role of community partners.
- Organizing and conducting quarterly coordination meetings: this enabled the partners to work in synergy and to make referrals of GBV survivors to the services that they need.
- Training health care providers on the management of care for survivors of SGBV. This activity enables them to identify, register and report them correctly.

1.3.5 Number of facilities that provide post-exposure prophylaxis (PEP) to GBV survivors

Figure 5: Number of facilities that provide post-exposure prophylaxis (PEP) to GBV survivors



During the period October 2016 – August2017, 37 facilities (representing 109% of the Y4 target) in the two IHPB PEPFAR provinces reported on PEP provision to GBV survivors (23 facilities from Kayanza and 14 from Kirundo). Important to note that in the non-PEPFAR provinces there are 30 facilities that offer PEP to GBV survivors (Karusi 14 and Muyinga 16).

Number of people trained on GBV case management

In Y4, IHPB trained 700 people - 20 trainers (15 male and 5 female), 163 health care providers (103 male and 60 female) and 517 community health workers (278 male and 239 female) on case management of GBV. This represents 112% of the Y4 target. All training organized by IHPB contributed to the indicators mentioned above (indicator 1.3.2, indicator 1.3.4 and indicator 1.3.5.).

CLIN 2: Increased Use of Quality Integrated Health and Support Services

LIN 2 serves as the locus of IHPB's work to strengthen community systems (Sub-CLIN 2.1), integrate and improve essential health services (Sub-CLIN 2.2); and strengthen HRH and related practices and systems (Sub-CLIN 2.3). Table below presents major Sub-CLIN 2.1, 2.2, and 2.3 Y4 activities.

Sub – CLIN	Major Y4 activities
Sub-CLIN 2.1 Increased access to health and support services within communities	• Organized nine communal level meetings in Kayanza • Piloted CHW peer supervision strategy in Vumbi health district • Conducted one-day orientation to 1,208 health center heads and heads of Comite Sante on community health system
Sub-CLIN 2.2 Increased percent of facilities that provide quality integrated health and support services	• Conducted intensified coaching support of QI teams in 12 sites in four provinces • 3rd learning session conducted in four provinces • 132 QIT set up in extension sites • 15 health workers in Kayanza trained on modern contraceptive technology
Sub-CLIN 2.3 Increased capacity of providers and managers to provide quality integrated health services	• supervision modules uploaded on the tablet • supervisors trained in it use. • OASIS user guide developed • Training data base updated regularly – 221 health workers, 299 COSA members and 1,531 CHWs trained in Y4

Y4 Progress and Discussion on Sub-CLIN 2.1 (*Increased access to health and support services within communities*) Result Indicators

Table 6: Y4 Progress and Discussion on Sub-CLIN 2.1

Indicator	Target FY 2017	Achieved
2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services	N/A	N/A[6]
2.1.2 Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)	80,000	164,380
2.1.3 Percent of health facilities that have functional CHW systems	25%	Not yet available[7]
2.1.4 Percent of COSAs that meet defined functionality standards	N/A	N/A[8]

2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services

The core package of quality integrated health and support services comprises the following components: FP counseling and provision of condoms and pills; antenatal care awareness; post-GBV care awareness and referral of survivors; awareness of HIV/AIDS and STIs; awareness of HIV counseling and testing; awareness and prevention of malaria; and nutrition awareness and screening of malnutrition. The indicator is informed by service availability and readiness assessments (SARA) conducted at the beginning, mid-term, and end of project. At baseline, none of the 164 health facilities provided the core package while at the midterm assessment implementation had improved to 36% (13 health facilities out of 36 that were involved in the survey). The LOP target of 40% is on target to be reached.

Training of CHWs on nutrition: During year 4, 431 CHWs from Kirundo and Mukenke were trained on the management of acute malnutrition at the community level, including screening, referral, and education. The training in these two final HDs completed the coverage of nutrition services provision at the community level in the 12 IHPB health districts.

Training of CHWs on FP: During year 4, 2,049 CHWs from Karusi, Kayanza, and Kirundo were trained on family planning including pills and condom provision and promotion of all contraceptive methods. Along with those who were trained during Y3, 94% of CHWs (3102/3284) were trained; the 6% remaining (182 CHWs) will be trained during Y5. In effect, SARA showed that 65% were not providing pills for FP, 31% wwere not providing post-GBV care awareness and referral of survivors; and 12% were not conducting malnutrition screening.

[6] Data are not collected annually, the indicator is informed by SARA at the beginning, mid-term, and the end of project

[7] Data are collected annually; will be available in November 2017, from the PBF monitoring system.

[8] Data are not collected annually, the indicator is informed by SARA at the beginning, mid-term, and the end of project

After the training of CHWs on various topics conducted from Y2 to Y4, the coverage of services provision is summarized in the table below:

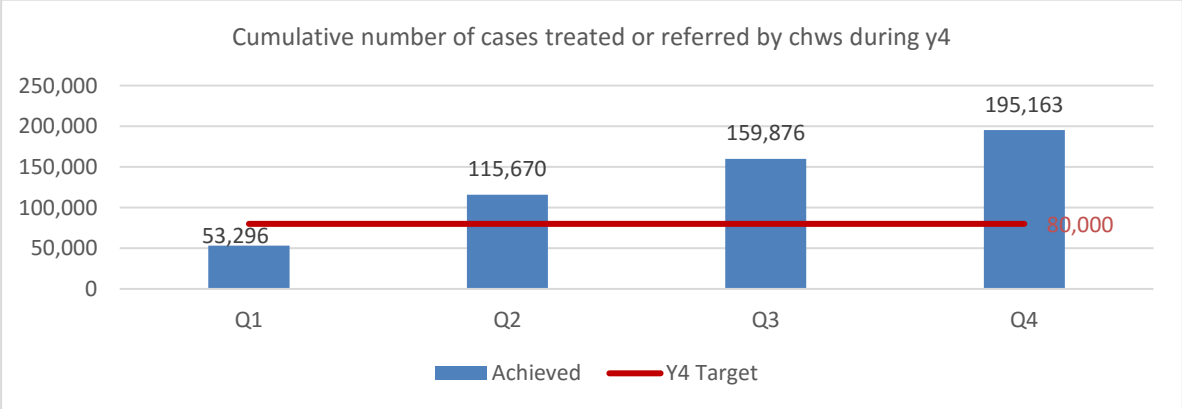
Table 7: Component of the core package of quality integrated health and support services

Component of the core package of quality integrated health and support services	Province			
	Karusi	Kayanza	Kirundo	Muyinga
FP Counseling and provision of condoms and pills	100%	100%	94%	86%
Antenatal care awareness	100%	100%	94%	86%
Post-GBV care awareness and referral of survivors	100%	100%	94%	86%
Awareness of HIV/AIDS and STIs	100%	100%	100%	100%
Awareness of HIV Counseling and testing	100%	100%	100%	100%
Awareness and prevention of malaria	100%	100%	100%	100%
Nutrition awareness, and screening of malnutrition	100%	100% with PI/ UNICEF	100% (81% with IHPB; 19% with CONCERN)	100% with PI/UNICEF

2.1.2 Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)

The data are extracted from the CHWs' monthly reports they transmit to the health centers as part of the iCCM strategy, and from the health center to the health district office. IHPB achieved 244% of the annual target, as shown in the graph below. The annual target was overachieved in Q2 as a result of increased community care by CHWs, given the malaria epidemic.

Figure 6: Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)

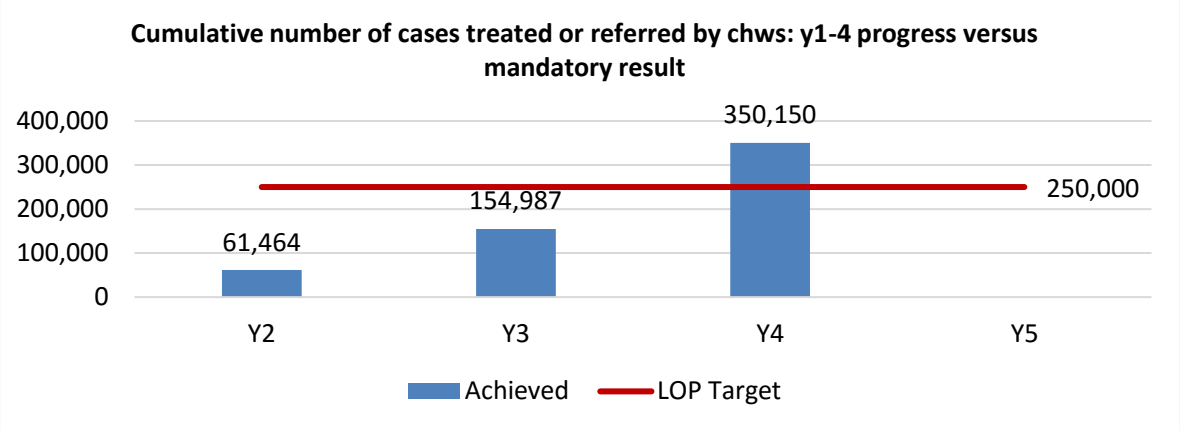


Training of CHWs on ICCM: CHWs from four health districts (Gahombo, Gashoho, Musema, and Kirundo) are providing treatment for malaria at the community level. During year 4 (since April 2017), the range of illnesses managed by CHWs was extended to include diarrhea and pneumonia and the number of children treated by CHWs increased. Thus, 34,826 cases were referred; 125,050 cases were treated including 107,238 for malaria, 15,524 for diarrhea, and 1,714 for pneumonia.

Improve CHWs' reporting system: Follow-up was improved by regular monthly report collection and data analysis. CHWs produce three reports: the ICCM report, the FP report, and the health promotion report. While a separate data analysis was conducted for each component during Y3, this was integrated in regular CHWs meetings organized at commune level during Y4. In addition, a database for community-based health data was designed to facilitate a quick data analysis at project level.

Trends against the LOP mandatory result:
From Y2 to Y4, a total of 350,150 cases were treated or referred by CHWs, exceeding the LOP target of 250,000, as shown in the chart below.

Figure 7: Cumulative number of cases treated or referred by CHWs: y1-4 progress versus mandatory result



2.1.3 Percent of health facilities that have functional CHW systems
This indicator is collected annually from a PBF database managed at province level of MPHFA. Health centers that meet functionality standards are those that have always scored 100% on the PBF indicator regarding CHWs activities during four consecutive quarterly quality evaluations. Data for year 4 will not be available before November 2017. While the baseline was 11% (18 HCs out of 164), the achievement in year 3 was 42% (70 health centers out of 168). By the mid-term evaluation, the LOP target of 31% was already overachieved.

CHWs peer-supervision:
IHPB implemented the CHW peer supervision strategy in Vumbi health district to supplement current forms of supervision undermined by the shortage in health promotion technicians. The strategy consists of grouping CHWs in small peer support groups with four to eight members, headed by a support group coordinator selected from among the CHWs. The CHWs in peer support groups organize joint activities, conduct supervisory visits to one CHW, and hold two meetings per month. The strategy was proceeded by the following activities: a 2-day briefing meeting with health system officials at the district and province levels, selection of the peer support groups coordinators, a 3-day training of the peer support groups coordinators, monthly report collection and analysis, and an evaluation meeting with the peer support group coordinators after three months of implementation.

Discussions conducted with support groups coordinators show that the strategy reinforces collaboration between CHWs, motivates CHWs, facilitates capacity building, and increases CHWs' credibility. The final assessment of the strategy will be conducted in February 2018 by focus group interview with the CHWs and the health center heads, and by analyzing the progress of quantitative data of CHWs services provision. The approach is sustainable since it is appreciated by the CHWs and requires no additional resources. In addition, the approach contributes to achieving results in MCH area, FP, malaria, GBV, HIV etc.

Implementation of the community score card:
In order to engage the community in activities related to their health and render service providers more accountable to the community, IHPB implemented the community score card approach. Conducted in a focus group, community members, CHWS, and local leaders meet to assess the quality of the community health activities conducted in their catchment area.

The community score card approach was implemented in 8 sub-colline sites. 16 facilitators, 3 health promotion technicians, and 13 facility-based care providers were selected to lead the groups. The facilitators engaged in 4-day training on facilitation of discussion groups.

Preliminary results have shown that the community members appreciate the activity because they were given a forum to express their comments and concerns about the community health activities and community members are more aware that community health activities are not just the responsibility of CHWs, but that everyone has a role to play. CHWs received feedback on their activities and could effectively adapt to community needs (e.g. build a road leading to the health center, organize educational sessions for youth, commit local leaders committing to conduct home visit to check the net use). Finally, facility-based care providers committed to addressing the areas of concern identified by the community.

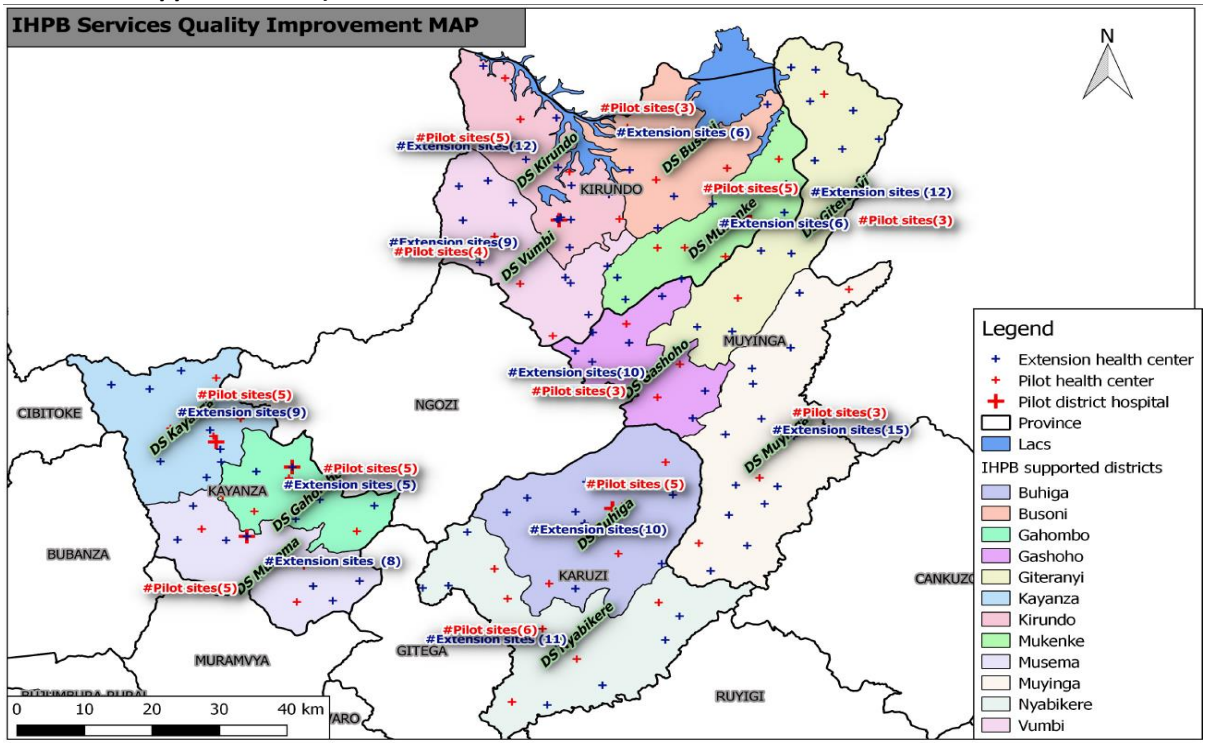
The community score card approach experienced some collateral benefits. Among the 16 community discussion facilitators, 10 were health care providers from health centers without HPTs, appointed as focal points for community-based activities, but did not know their scope of work. These providers will be involved in provision of injectable contraceptives at the community level. Additionally, those who worked as community discussion facilitators learned the concerns of the community with some behavior of health centers staff, and they have committed to addressing the issues in their respective health facilities.

2.1.4 Percent of COSAs that meet defined functionality standards

A functional COSA is defined as meeting all of the following standards: participate in annual planning; have monthly meetings with verified meeting reports; discuss the financial situation of the health center; and evaluate action plans. Financial situation follow-up is challenging for closer members because they are not familiar with the procedures and tools used. The information is pulled from a facility-based survey conducted through interviews with COSA members at the beginning, mid-term, and end of project. While the baseline was 67.7%, the achievement at mid-term was 61.1% (mid-term target was 72.7%). The target was underachieved because year 3 coincided with the COSA renewals in Karusi, Kayanza, and Kirundo provinces. In effect, the policy provides that COSA is renewed every 5 years; new members are elected to replace the former ones. Project mid-term interviews were conducted with COSA members who have just been elected, without any training.

To address the underachievement, IHPB trained COSA members on their scope of work via a one-day training organized for 847 members of COSAs (371 females and 476 males) from Karusi and Kayanza provinces. The support provided by IHPB to COSAs reached Karusi and Kayanza provinces; Kirundo and Muyinga were covered with the support from Conseil pour l`Education et le Developpement (COPED). During Y5, supervisory visit will be conducted to all COSAs in Karusi and Kayanza; partticioation in work planning and in Work Plan Assessment will be explored and monthly meeting reports will be analyzed.

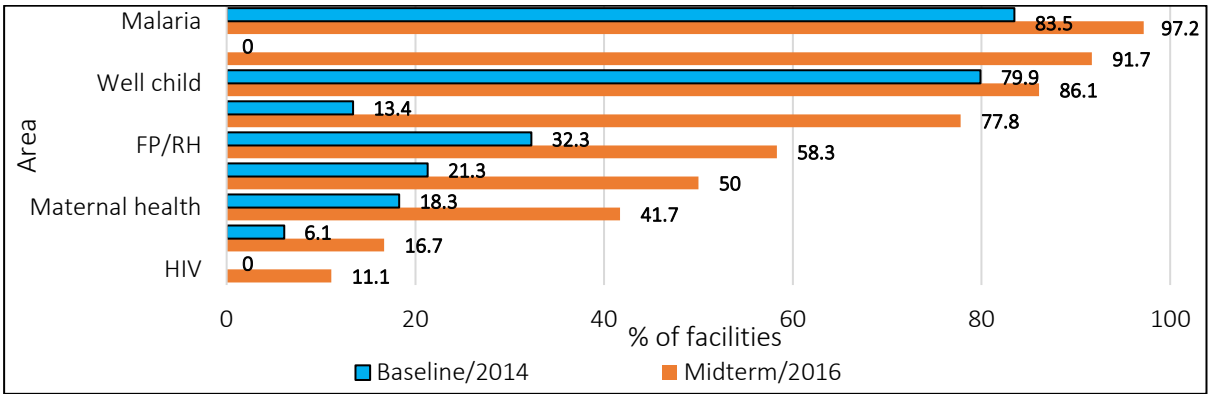
Y4 Progress and Discussion on Sub-CLIN 2.2 (*Increased percent of facilities that provide quality integrated health and support services*) Result Indicators



IHPB strategy to achieve sub-CLIN 2.2 results is to support smart integration of services, using the Improvement Collaborative model where facility teams make changes in the organization of services so that they reduce missed opportunities to deliver services in an integrated way. Each province works on a different integration objective. By the end of Y4, the changes that led to successful integration of services were identified in each province and extended to all facilities within that province, leading to the following results:

2.2.2 Percent of supported health centers that provide a core/expanded package of quality integrated health services

Figure 8: Percent of supported health centers that provide a core/expanded package of quality integrated health



In 2014, the baseline Service Availability and Readiness Survey (SARA) conducted by the IHPB revealed that less than 40% of facilities were delivering an integrated core /expanded package of services in ANC, GBV, FP/RH, Maternal health, PMTCT, Child curative and HIV. This indicator is measured 3 times during the period of project implementation: baseline, mi-term and end of project. One should note that this is a very strict standard - if a facility fails to provide any of the comprehensive set of services listed in the PIRS, it is recorded as “does not meet the standard” and therefore receives a score of zero. This explains the low score for ANC as many facilities provided most/all of the services except for the intermittent preventive treatment in

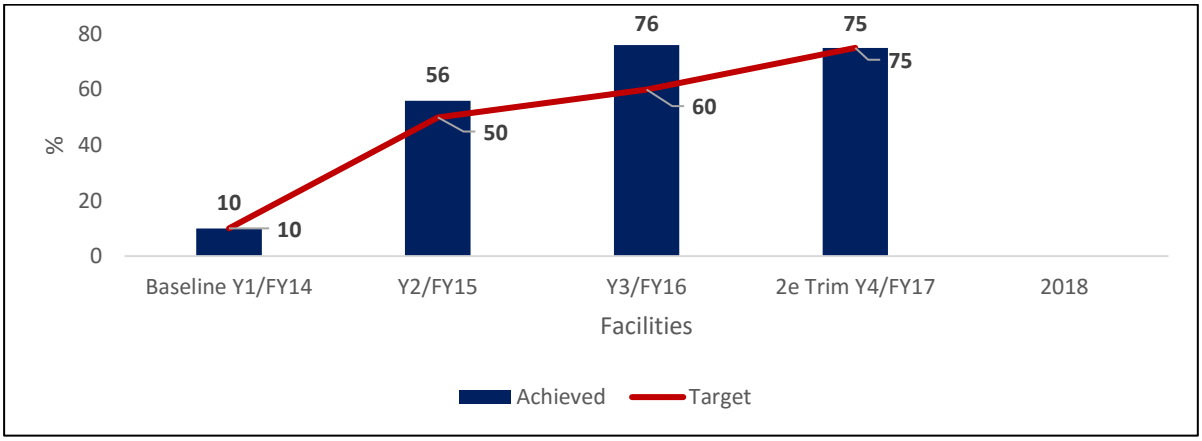
pregnancy (IPTp) for malaria (this was before HPB started training of health workers) and HIV-related voluntary medical male circumcision, palliative care services, VBG Screening and management and counseling and nutritional support. The list of services considered for measurement of this indicator is available in the PIRS document shared with USAID.

Integrating ANC and GBV into curative care services *(Kirundo*), FP into immunization and post-natal care services (*Karusi and Kayanza*), and IPTp into ANC services (*Muyinga*) through a combination of competency-based trainings and QI activities resulted in a significant increase of the proportion of facilities that provide all types of services in an integrated way. SARA midterm (2016) results shows that the expected results by the EOP have already been achieved and exceeded for all types of clinics in health centers.

2.2.3 Percentage of facilities that perform to national technical and quality standards

The expected results by the EOP is to increase by 10 % the number of facilities (hospitals and health centers) that score at least 70% for technical quality as assessed through the MPHFA's measurement tool of the Performance-Based Financing (PBF) System.

Figure 9: Percentage of facilities that perform to national technical and quality standards



The figure above shows that this mandatory result has already been achieved, benefiting from the contribution of QI, training and supervision efforts supported by IHPB. QI activities include a checklist of quality standards which are assessed during joint coaching visits by coaches and QI officers.

Contribution of QI activities to other IHPB mandatory results

IHPB is supporting the specific-province project integration initiative mentioned in table below.

QI/Integration contribution to MCH services

QI contributed to increase early ANC care services (first ANC visit before 12 weeks). From October 2016 to July2017, a total of 2,261 pregnancies were identified from women attending curative care services because of the systematic integration of questions on amenorrhea by service providers in Kirundo HP. 1,982 of them (88%) were less than 12 weeks of amenorrhea and benefited from early ANC through immediate referral that included a package of services like HIV counseling and testing, IPTP, LLITNs, and PMTCT on the same day.

QI/Integration contribution to FP services

In Y4, QI/Integration efforts have significantly increased the number of new acceptors of long-term contraceptive methods in Karusi province: Out of 4,435 implants acceptors the 11 sites with QI integration teams contributed to 2,295 (52%) of new implants acceptors. Out of 570 new IUD acceptors in the whole health province, 376 (66%) were from QI sites. These results are achieved through a combination of project support that include the Integration of FP services into immunization and maternal and child health (MCH) services, hence contributing to indicator 2.0.1 (Couple year protection in USG supported programs)

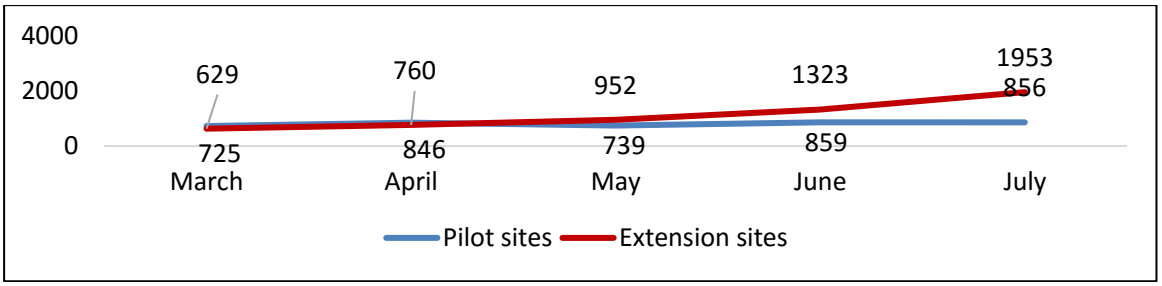
QI/Integration contribution to HIV services

Starting in February 2017, IHPB supported the integration of HIV services into curative care in Kirundo through the addition of indexed counseling and testing. The results shown in run chart below contribute

the following indicator: *2.09 (Number of individuals who received Testing and Counseling services for HIV and received their results)*

Number of indexed patients counseled and tested for HIV curative care at pilot and extension sites (Kirundo Province)

Figure 10: Number of indexed patients counseled and tested for HIV curative care at pilot and extension sites (Kirundo Province)



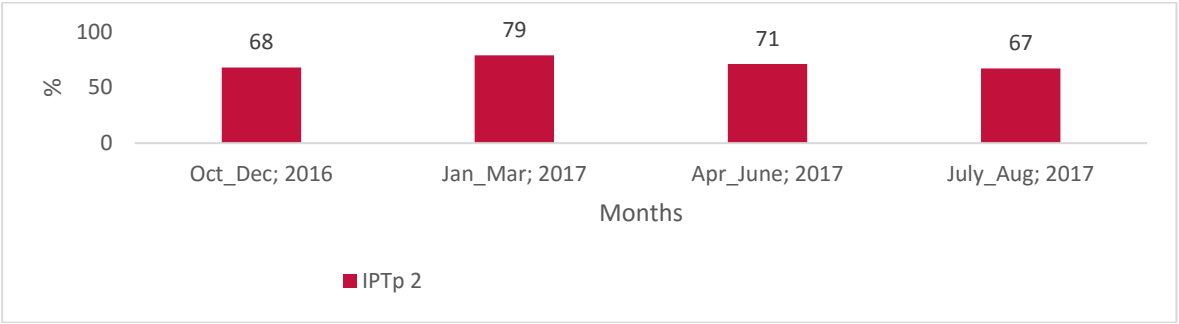
From March to July 2017, 7,184 clients seen in curative care services were screened for HIV in Kirundo province and therefore know their serological status.

QI/ integration contribution to malaria services in Muyinga Province

From October 2016 to August 2017 a total of 7,034 out of 10,022 (70 %) pregnant women seen in ANC3 received two doses of Fansidar with an average of 71% in pilot sites and extension sites, contributing to a significant increase in IPTP2.

% of pregnant women seen in ANC3 who received iPTp2 in QI sites

Figure 11: % of pregnant women seen in ANC3 who received iPTp2 in QI sites

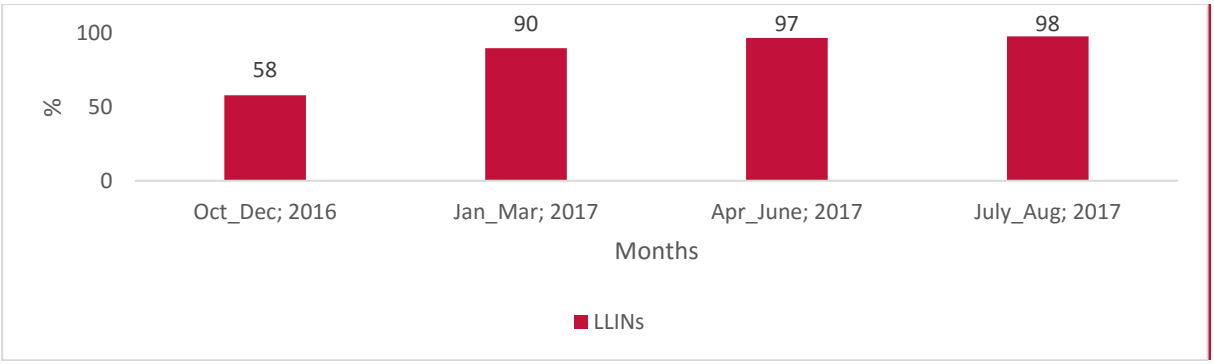


During the same period, a total of 11,206 out of 12,107 (93%) of pregnant women attended in ANC1 received LLITN from QI sites of Muyinga HP.

Note that data for September 2017 are not yet available.

% of pregnant women seen in ANC1 / facility`s responsibility area who benefited from LLINs

Figure 12: % of pregnant women seen in ANC1 / facility`s responsibility area who benefited from LLINs



Y4 Progress and Discussion on Sub-CLIN 2.3 (*Increased capacity of providers and managers to provide quality integrated health services)* Result Indicators

Table 8: Progress and Discussion on Sub-CLIN 2.3

Indicator	Target FY 2017	Q 1 Results	Q 2 Results	Q3 Results	Q4 Results	Y4	EOP
2.3.1. Percent of project-trained health providers, managers and CHWs who perform to a defined standard post-training	95%	N/A[9]	N/A	N/A	N/A	97.4%	95%
2.3.2. Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training	90%	98.4%	94.7%	92.3%	93%	94.6%	95%
2.3.3. Percent of trained health care staff who report positive attitudes (composite indicator) about work and the workplace[10]	69%	79.2[11]		N/A	N/A		80%
2.3.4. Percent of supported facilities with at least 80% of clients reporting satisfaction with services received[12]	100%						100%
2.3.5. Number of health care workers who successfully completed an in-service training program	1,525	158	694	257	149	1,258	
2.3.6. Number of community health/para-social workers who successfully completed a pre-service training program	6,558	1,716	2,682	1,830	2,881[13]	9,109[14]	

Percent of project-trained health providers, managers and CHWs who perform to a defined standard post-training (FY 2017 target of 95%)
IHPB measures this indicator through the supervision visits of district supervisors, with the use of a tool specifically designed to assess the implementation of the trainee's plan. In Y4, the number of trainees assessed was low (54) due to the lower frequency of supervision visits - non-systematic use of the assessment tool.

2.3.2. Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training (FY 2017 target of 90%)
The training data base established by IHPB allowed capturing the progression of scores pre-and post-test. We observed an increase in scores with results well above the target of 90% i.e. 94.6%.

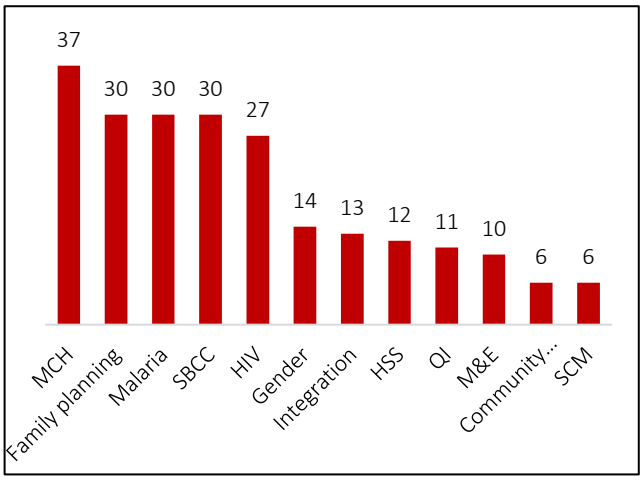
In Y4, the HR training database that IHPB started using was reformatted to harmonize data specifications with MPHFA standards (information available in the Excel-database of its Human Resources Department) and the national human resources information system (IHRIS), expected to be rolled-out in all districts[15]. This will allow information in the IHPB training database to be easily uploaded into the IHRIS for districts to conduct and improve their essential human resource management function.

[9] This indicator is only measured annually
[10] This indicator is collected at baseline, mid-term and end-term.
[11] Mid-term evaluation results
[12] This indicator is extracted from the PBF database – data not yet available.
[13] CHW trained twice and 41 peer educators
[14] Idem 4
[15] At the time of the writing of the Y4 Annual Report, the MPHFA has not indicated a timeline for the HRIS roll out.

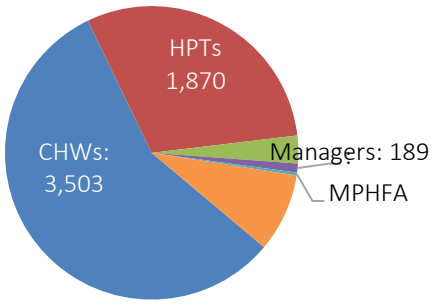
In Y4, IHPB has achieved or is on track to complete the targets set for Y4 and all HRH MRs by the end of project. Starting in Y2, the project established an Excel-based database of all trainings and trainees supported by IHPB that collects information to track progress against indicators/MRs 2.3.1 and 2.3.2. In Y4, IHPB has supported training of 6,177 personnel (46% of who are women) through 226 training events and 11,947 learner sessions. Training distribution by topic and category of participants are presented in Figures below.

Figure 13: Number of training by topic and training participants

NUMBER OF TRAININGS BY TOPIC



TRAINING PARTICIPANTs



2.3.3. Percent of trained health care staff who report positive attitudes (composite indicator) about work and the workplace[16] (FY 2017 target of 69%)

For this indicator, the initial target (66%) was largely exceeded. The mid-term evaluation evaluated is at 79.2%. To strengthen the capacity of district supervisors to improve the performance of service providers, IHPB developed a tablet-based integrated assessment and improvement tool to be used during supportive supervision visits, named OASIS (*Outil d'Amélioration des Services Integrés de Santé).* The OASIS tool is composed of a series of 13 modules that follow the MPHFA supervision guide, organized by service, and integrating quality improvement approaches. Modules are available in French and Kirundi. A server collects data sent from the tablets after the supervision visit so that they may be extracted for reporting, analysis and action. As of August 2017, 12 modules have been finalized and eight have been uploaded and tested. Fifty-two users (supervisors and PTOs) have been trained in OASIS, including 10 staff from MPHFA's *Direction de l'Offre et de la Demande des Soins* (DODS). DODS has expressed interest in scaling up use of the OASIS tool nationally.

CLIN 3: Strengthened Health Systems and Capacity	
Sub – CLIN	**Major Y4 activities**
Sub-CLIN 3.1 Strengthened decentralized healthcare and systems in targeted geographic areas	• Provided technical and financial support to the organization and conduct of joined quarterly data analysis & coordination meetings • Conducted an assessment of the effectiveness of coordination meetings • Participated in formative supervision visits focusing on HIV laboratory activities • Signed equipment maintenance contract with Hospital Management Services • Assessed the functionality of the district supervision system
Sub-CLIN 3.2 Strengthened M&E and data	• Conducted data quality assessment exercises to verify indicators for IHPB supported services

[16] This indicator is collected at baseline, mid-term and end-term.

management systems at facility and community levels	• Strengthened district teams and facility managers capacity on data use through quarterly meetings • Conducted coaching visits for data visualization dashboards in IHPB supported facilities
Sub-CLIN 3.3 Increased civil society capacity to support positive behaviors and quality integrated services	• Conducted a supervision visit focused on the execution of contract between FHI and ANSS • Submitted approval requests to re-establish partnership with SWAA Burundi and RBP+ and recruitment of Red Cross for GBV activities

Y4 Progress and Discussion on Sub-CLIN 3.1 (*Strengthened decentralized healthcare and systems in targeted geographic areas*) Result Indicators

In Y4, IHPB continued to work collaboratively with BDS and BPS to strengthen district health teams' capacity to perform priority functions that most affect the delivery of services. Some of these functions are addressed under other sub-CLINs, such as the management of supplies (sub-CLIN 1.2), quality management of service delivery (sub-CLIN 2.2), management of human resources (sub-CLIN 2.3) and management of health information system (sub-CLIN 3.2). The table below summarizes the performance of IHPB against the mandatory results specific to Sub-CLIN 3.1.

Table 9: Y4 Progress and Discussion on Sub-CLIN 3.1

Indicator		Y4 Target	Y4 Results
3.1.1. Percent of supported facilities that have available all current national health policies, protocols, and guidelines	FP/RH	24.42%	31.5%
	ANC	38%	42.3%
	Maternal Health	49%	44.6%
	Child Health	27%	45.4%
	HIV	50%	64.8%
	Malaria	98%	91.3%
	GBV	33%	36.5%
3.1.2. Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services		51%	51.1%
2.2.4. Percent of supported facilities that receive supportive supervision on a regular basis		100%	82.07%
3.1.5. Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis		100%	100%

3.1.1. Percent of supported facilities that have available all current national health policies, protocols, and guidelines

Figure 14: Percent of supported facilities that have available all current national health policies, protocols, and guidelines

IHPB continue its annual improvement trend and all targets have been achieved except for the documents related to maternal health and malaria services. The availability of documents is verified during joint supervision visits and missing documents are replaced or provided during the next visit. It must be noted that the somewhat low numbers are partially explained by the strict criteria used to measure this indicator, which requires that every policy, protocol and guideline document be available for each domain to be scored as having met the criteria. If one document is missing, it is noted "0". There are new documents produced by the Ministry of Public Health and the Fight against AIDS (MPHFA) and IHPB continue to provide support in printing/photocopying of these new documents. Some health providers take the documents with them when they are transferred to another location, hence their replacement is a continuous activity.

IHPB started transitioning this document management function to district health teams by sharing the computerized database of key documents and including an inventory module in the Outil d'Amélioration des Services Intégrés de Santé (OASIS), the electronic tool for supervisors During Y4, reproduction and costs

of these documents relied entirely on the project. During Year 5, distribution of these documents will be done by district supervisor during supervisions visits.
The table below shows the situation on the availability of each type of documents (results of an inventory done in September) against LOP targets and the progress from the baseline.

Table 10: Percent of supported facilities that have available all current national health policies, protocols, and guide lines

Percent of supported facilities that have available all current national health policies, protocols, and guide lines				
	Documents	Baseline 2014	Y 4 achieved	LOP Target
1	FP/RH	16.20%	31.50%	21.20%
2	ANC	8.10%	42.30%	13.10%
3	Maternal Health	12.70%	44.60%	17.70%
4	Child Health	15.60%	45.40%	20.60%
5	HIV/AIDS	0%	64.80%	5%
6	Malaria	89%	91.30%	94%
7	GBV	11%	36.50%	16%

3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services
This indicator remained at 51.1%, having increased significantly from 26.6% at baseline due to the project supply of medical equipment in Y2. Since Y2, no additional equipment was provided and the mandatory result has been achieved.

To ensure that equipment provided by IHPB remains functional, we continued our maintenance contract with Hospital Management Services (HMS) for preventive maintenance and with the Kenya branch of Becton Dickinson (BD) that performs an annual preventive visit and responds to emergency breakdowns of CD4 machines. Examples of maintenance and repair services performed in Y4 include: HMS repaired beds in Kirundo, Mukenke and Kayanza health districts, anesthesia machine, incubators, fridges, surgical bistoury and theater lamp in the 10 district hospitals and the gynecological examination tables, goose lamp for gynecological examination, scales adult, hemoglobinometers, table resuscitation of newborn in different health facilities of the twelve health districts.

IHPB worked with district teams to review their equipment inventory system and its regular update through the supervision visits and address issues as needed. During Y5, district supervisors who were initially doing the inventory hand in hand with the PTOs will have to perform this task on their own and share reports to IHPB.
The sustainability of equipment maintenance remains an issue as it relies entirely on the project and the MPHFA budget is insufficient.

2.2.4 Percent of supported facilities that receive supportive supervision on a regular basis
This indicator has increased during the fourth year of the project, from 78% in Y3 to 82.07% in Y4. This indicator measures only the supervision visits conducted by the district supervisors (not the IHPB staff) and is extracted from the GESIS/DHIS2 databases. This is partially due to better planning and the financial support via sub-grants to districts to conduct joint (IHPB PTO and District Supervisor) and integrated site

visits. In Y4, of the 1,946 supervision visits planned, a total of 1,597 supervision visits were implemented (82.07%). The table below shows the situation in each health district.

Table 11: Percent of supported facilities that received supportive supervision on a regular basis

Health district	Number of Supervision visits planned	Number of Supervision visits implemented	Percentage
DS Buhiga	158	135	85.44%
DS Busoni	104	79	75.96%
DS Gahombo	150	142	94.67%
DS Gashoho	125	122	97.60%
DS Giteranyi	157	138	87.90%
DS Kayanza	241	211	87.55%
DS Kirundo	198	102	51.52%
DS Mukenke	115	114	99.13%
DS Musema	139	115	82.73%
DS Muyinga	245	198	80.82%
DS Nyabikere	190	129	67.89%
DS Vumbi	124	112	90.32%
Total	**1946**	**1597**	**82.07%**

In addition to the development of an integrated electronic tool (OASIS) for supervisors to assess and improve FOSA performance (described under sub-CLIN 2.3), IHPB conducted a rapid survey to assess the functionality of the district supervision system and identify the factors that affect the planning, implementation and quality of supervision, an essential function of the district management team.

The analysis showed the following strengths and weaknesses:

Strengths:

- In 58% (7/12) of districts, the supervisors correctly prepare the supervisions according to a set of criteria;
- In 58% (7/12) of districts, facilities received the minimum required number of visits in the last quarter,
- 100% of facility managers and supervisors think that the frequency of supervision is adequate to meet facility's needs and;
- All supervision recommendations from the past 3 visits have been implemented in 16.7% (6/36) health centers of the 12of HD.

Weaknesses:

- in 33.3% (4/12) of districts, supervision visits happen as planned (Gahombo, Kayanza and Musema in Kayanza health province and Buhiga in Karusi health province);
- 33.3% (4/12) of districts do not develop a supervision plan;
- 25% (3/12) of districts do not review necessary documents to inform the supervision visit (facility performance indicator);
- In 25% (3/12) of districts, supervision visits were conducted per MPHFA Guidelines In 41.7% (5/12) of districts
- 25% (3/12) of districts do not inform facilities of the visit at least 1 week in advance;
- Some supervisors do not hold a brief meeting with facility staff before starting the supervision visit in some health centers;
- In 58% (7/12) of districts, supervisors do not hold a joint meeting with staff to review findings of supervision and discuss problem solving;
- In 41.7% (5/12) of districts, supervisors don't give a copy of the report to the facility manager (feedback);

- Lack of district-based supervisors and lack of transport to conduct supervisions;
- Too many functions/services to supervise during one visit;
- Not all supervision recommendations are implemented because the timetable is not clearly established or due to some factors are not under the control/authority of the health facility level (stock out at CAMEBU).

3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis

This indicator remains at 100% as all district conduct their annual planning (a requirement of the MPHFA) and as IHPB supports (financially and technically) quarterly coordination meetings, which are now merged with the data analysis meetings described under Sub-CLIN 3.2.

A coordination meetings assessment tool was developed to measure the effectiveness of the coordination meetings and improve their effectiveness in problem solving and decision-making based on data. Analysis of these meetings showed the following strengths and weaknesses:

Strengths:

- Health district teams consider that the meeting is a relevant activity where participants gather to perform work that requires a team effort;
- The meetings are now preceded by planning, with an explicit focus/agenda, and a budget. Before the IHPB support, many coordination meetings were postponed due to lack of budget.
- Health districts, their partners and other stakeholders know that during these meetings, the ultimate goals are agreements, decisions, or solutions.
- Jointly with districts, the agenda of the meetings are developed and include the issues related to the achievement of IHPB mandatory results;
- Every health district presents the progress indicators (performance) for each health facility, strengths and weaknesses;
- Decision to develop joint schedule of supervision visits monthly has been made in all 12 supported districts.

Weaknesses:

- Health district teams don't develop meeting agenda and produce the meeting reports but they receive them from PTOs;
- Presentations are not prepared on time and in substance during these meetings.

During the planning sessions, IHPB staff and district authorities will reflect on the challenges they face with planning, develop solutions to address them with the provincial and national levels, and address sustainability issues by transferring the activities of the Project to the district teams over a period of 6 months.

Y4 Progress and Discussion on Sub-CLIN 3.2 (*Strengthened M&E and data management systems at facility and community levels*) Result Indicators

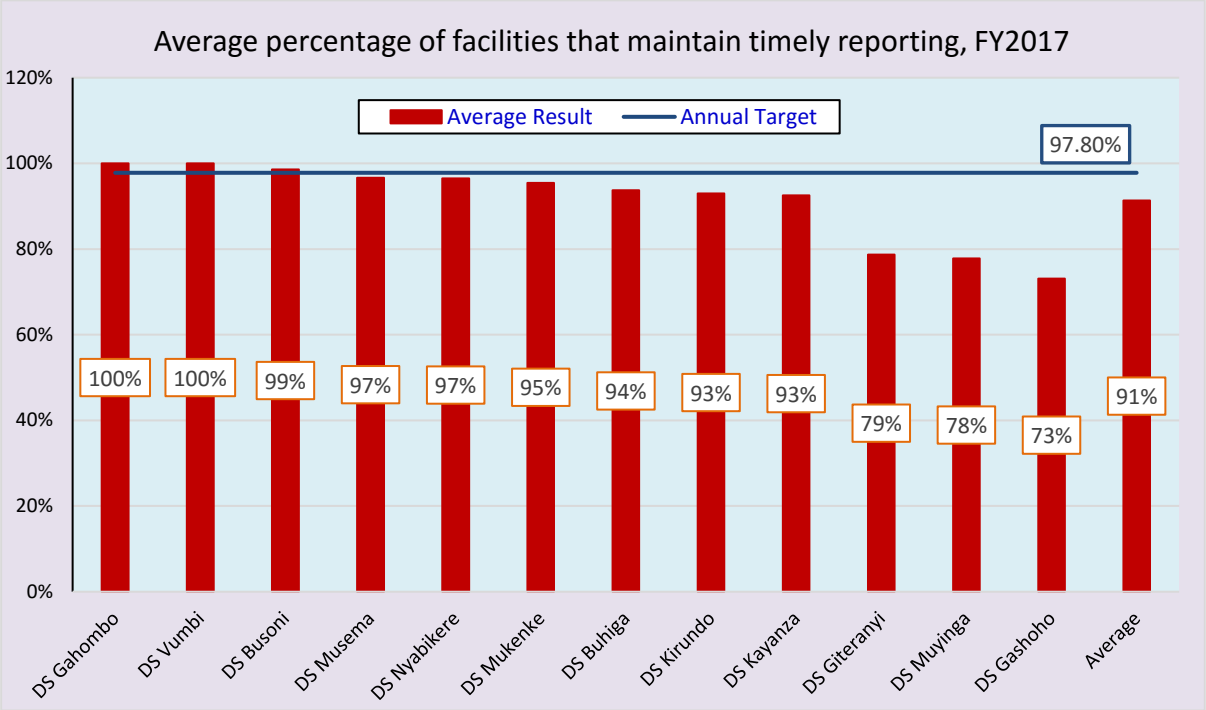
Table 12: Y4 Progress and Discussion on Sub-CLIN 3.2

Indicators	Target FY 2017	Results FY 17					Y5/EOP Target
		Q1	Q2	Q3	Q4	Average Result	
3.2.1 Percent of facilities that maintain timely reporting	97.8%	100%	77%	94%	95%	91%	100%
3.2.2 Percent of districts and facilities that demonstrably use facility- and community-level data for timely decision making	Facility: 95%	94%	94%	Facility: 94%	94%	94%	Facility: 97%
	District: 90%	89%	89%	District: 89%	89%	89%	District: 85%

During the four years IHPB, jointly with provincial and districts teams, has conducted training, supportive supervision, routine data quality assessment exercises and quarterly data review workshops at community, facility, district and provincial levels.

3.2.1 ***Percent of facilities that maintain timely reporting***

Figure 15: Percent of facilities that maintain timely reporting



Most districts are meeting the performance targets. The three districts of Muyinga province have a performance lower than the overall average (91%), due to the late introduction of the DHIS2.

3.2.2 Percent of provinces, districts and facilities that demonstrably use facility- and community-level data for timely decision making

IHPB is on track to achieve its targets by the end of the project.

To reach and maintain that performance, IHPB conducted a series of activities:

a) At the request of the Department of National Health Information System (DNHIS) following the introduction of updated DHIS2 customized tools, IHPB first conducted a training of 48 trainers (35 males and 13 females) from Karusi (10), Kayanza (12), Kirundo (15) and Muyinga (11) on the new data collection and reporting tools set for DHIS2. Attendees included BPS and BDS HIS in-charges and supervisors along with IHPB monitoring and evaluation technical officers. With the contribution of the new trainers, IHPB partnered with the BPS and BDS health authorities to train 267 health providers (197 male and 70 female) from Karusi (65), Kayanza (62), Kirundo (71) and Muyinga (69), on the use of data collection and reporting tools. Four training sessions were conducted separately, each in the respective provinces as planned.

Province	# Trainers trained	Health providers trained
Karusi	10	65
Kayanza	12	62
Kirundo	15	71
Muyinga	11	69
Total	**48**	**267**

b) Quarterly Data Quality Assessment (DQA) exercises conducted jointly with provincial and district HIS in-charges in 139 health facilities out of the 184 IHPB-supported spread in the four-project supported provinces revealed an average variance of 3.7% between the data in IHPB database and that verified in source documents, indicating a very good performance according to international standards that accept a maximum variance of -/+5%. However, the Q2 variance rate in Kirundo exceeded the acceptable range due to a low performance Q2 of some facilities of Busoni Health District on indicators related to PCR and ART data. An improvement plan was developed and better performance achieved in Q3.

Province	Q1	Q2	Q3	Average variance (%)
Karusi	0.6	3.3	1.6	**1.8**
Kayanza	3.9	2.8	4.6	**3.8**
Kirundo	-	8.0	2.5	**5.2**
Muyinga	3.4	5.2	3.9	**4.1**
Average	**2.6**	**4.8**	**3.1**	**3.7**

An overall routine data quality assessment was conducted in September 25-29, 2017 on 11 key indicators in 20 facilities distributed across the four supported provinces (five in each). As depicted in the table below presenting the data quality average variance rate by indicator across provinces, the overall variance rate observed is 5.8%. Although the variance rate meets the USAID data quality standard of +/-10%, it is slightly beyond the FHI 360 standard variance rate due to an over-reporting in Karusi and Muyinga on information related to administration of uterotonics in the third stage of labor, and to new clients accepting FP methods (Karusi in Q1 and Kayanza in Q2), and an underreporting of supervisions seen in Kirundo and Karusi. After correction, improvement was obsreved in Q3 with an average variance rate of 1.9%.

Data variance across provinces on a sample of facilities, September 2017 (a negative indicates an under-reporting)

Table 13: Data variance across provinces on a sample of facilities

#	Indicators	Kayanza	Kirundo	Karusi	Muyinga	Average variance (%)
1	Proportion of pregnant women attending early ANC1	0.0	-3.7	4.9	2.2	**0.9**
2	Proportion of pregnant women attending ANC3 who received at least IPTp2 (SP2/SP3) under direct observation of a health worker	2.3	3.9	-0.2	0.7	**1.7**
3	Percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs	0.0	0.4	109.0	14.7	**31.0**
4	Proportion of children under five who received ITNs during measles immunization	0.3	4.6	-1.6	-0.2	**0.8**
5	Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs	0.8	11.3	5.1	-0.8	**4.1**
6	Percent of supported facilities that receive supportive supervision on a regular basis (at least once in 2 months)	-2.2	-20.0	-8.9	-3.3	**-8.6**
7	Number of new clients who accepted family planning methods	24.5	3.4	91.0	2.4	**30.3**
8	Number of individuals who received HIV Testing Services (HTS) and received their test results	6.6	2.2	NA	NA	**4.4**
9	Percentage of HIV-positive pregnant women who received ART to reduce the risk of mother-to-child-transmission (MTCT) during	0.0	0.0	NA	NA	**0.0**

#	Indicators	Kayanza	Kirundo	Karusi	Muyinga	Average variance (%)
	pregnancy (includes 1) New on life-long ART, 2) Already on life-long ART at the beginning of the current pregnancy					
10	Number of adults and children currently receiving antiretroviral therapy (ART)	-1.7	-0.2	NA	NA	**-0.9**
11	Number of new and relapse TB cases with documented HIV status, during the reporting period	0.0	0.0	NA	NA	**0.0**
Average						**5.8**

c) Technical assistance and support to quarterly review workshops to strengthen capacity of district teams and facility managers on data use. Those workshops call together district health teams along with heads of health facilities to review and discuss the quality of data as well as performance of facilities. Findings of supervisions and DQA exercises are also discussed during those meetings.

d) Technical assistance and coaching of health facilities to develop data visualization dashboards on key activity indicators (immunization rate, ANC coverage, FP uptake, malaria cases, and other notifiable diseases) to foster data use.

e) In partnership with the Department of Offer and Demand of Care Services (DODS), IHPB developed a database and user guide on iCCM (Integrated Community Case Management) with the inclusion of community driven data on malaria, pneumonia and diarrhea components. The database is used in six project-supported districts (Gahombo, Musema, Gashoho, Giteranyi, Muyinga and Kirundo) implementing iCCM.

f) As part of the technical support to the MPHFA, IHPB actively participated in the HIV tools review workshop organized by the National Program for AIDS Control in Gitega (Aug 22-25, 2017)

Y4 Progress and Discussion on Sub-CLIN 3.3 (*Increased civil society capacity to support positive behaviors and quality integrated services*) Result Indicators

In Y4, IHPB envisioned to work with the three CSOs mentioned below and engage them in the following interventions:

- ANSS[17] and SWAA[18] Burundi to strengthen HIV activities and integration of malaria, FP, child health, tuberculosis, and non-communicable diseases respectively in Kirundo and Kayanza provinces;
- RBP+ to implement community-based activities to increase screening, improve the demand for care by PLHIV, adherence to and retention of PLHIV on ART in Kirundo and Kayanza provinces and
- Burundi Red Cross to better ensure the prevention, support and comprehensive care to SGBV survivors in Karusi province.

In Y4, in addition to developing program descriptions and respective budgets for SWAA Burundi, RBP+ and Burundi Red Cross and submission to USAID for approval, IHPB CSO activities focused on monitoring implementation of the ANSS sub-grant. Regular supervisions were conducted, focused on organizational activities and technical activities as well.

By taking care of 1,034 PLHIV out of 5,419 or 19%, the Kirundo ANSS clinic is the site in the province with the largest number of PLHIV in care:

- ANSS: 1,034 (19%)
- Health centers of Vumbi district: 998 (18%)
- Mukenke hospital: 832 (15%)
- Health centers of Busoni district: 733 (14%)
- Health centers of Kirundo district: 710 (13%)

[17] A grant has been already awarded to ANSS from July 1, 2016-September 30, 2018

[18] For SWAA Burundi, RBP+ and Burundi Red Cross, the program descriptions and budgets have been finalized, submitted to USAID and are awaiting approval.

- Health centers of Mukenke district: 565 (10%)
- Kirundo hospital: 547 (10%)

The results of this clinic exceed the targets that were set illustrated by (1) the number of people tested for HIV, (2) the number of viral loads performed, (3) the number of children tested using PCR for early diagnosis.

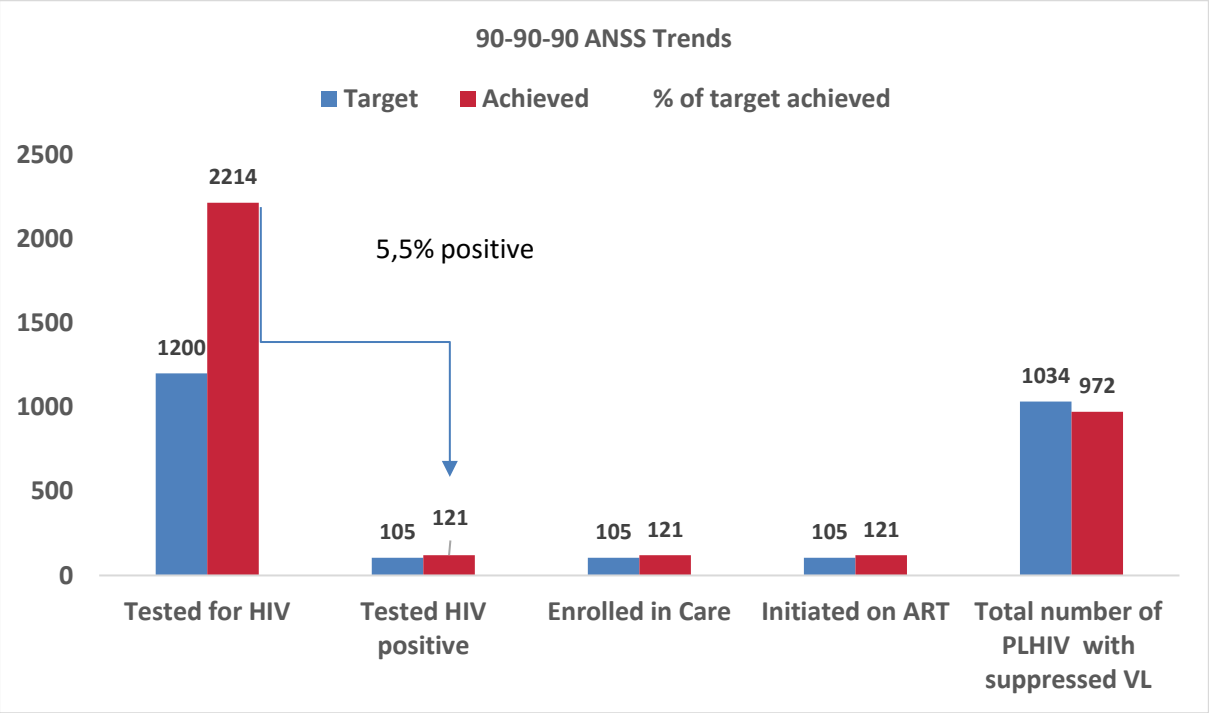
Number of people tested for HIV

IHPB provides technical assistance to ensure that HIV testing initiated by the provider continues, 98% of clients tested receive their results and all HIV-positive patients are treated. The target of 1,200 people tested that was set for this fiscal year which runs from October 2016 to September 2017 has been largely exceeded (2,214 people tested i.e. 184.5%) while data of September are not yet included.

Number of viral load

The objective is to have an undetectable viral load after 6 months of treatment. ANSS performed 1,034 VL and 94% of patients had an undetectable VL.

Figure 16: 90-90-90 ANSS Kirundo Trends



Children tested using PCR

In the national policy, early diagnosis of HIV is recommended through PCR at birth and at 9 months. IHPB supported the ANSS Kirundo clinic in carrying out these examinations and particularly in the transport of samples. It was planned to perform 45 PCR analyzes and 60 were performed.

The ANSS Kirundo clinic operates in accordance with national AIDS policies, including the implementation of the 90-90-90 strategy. In the 2016-2017 fiscal year, out of 2,214 patients screened, 121 were diagnosed as seropositive, a rate of 5.5%, all were placed on ARV (enrollment rate: 100%) and viral load analyzes performed six months later showed that 94% had undetectable VL. In addition, the Kirundo ANSS clinic distributed a total of 43,409 condoms to its clients in Y4.

Priority Health Domains

While IHPB pursues integrated solutions to address individual, household, and community health needs, the project remains committed to ensuring that the interventions it promotes align with latest scientific evidence and USG standards and norms for effective programming in specific technical domains. In addition to the different SBCC and health systems strengthening activities described above under each sub-CLIN and that contribute to each health domain, we are presenting here specific health domain activities related

mainly to building providers' capacity in the content of care and services. Following are project's major Y4 activities for priority health domains.

Health Domain	Major Y4 Activities
HIV/AIDS	• Provided in-kind grants (IKG) to 12 BDS and nine district hospitals • Implemented strategies that target people with high risk; increase enrollment on ART; follow up PLWHIV to stay on ART; and assure follow up of PLHIV to stay on ART • Index testing?
Malaria	• Continued implementing intermittent preventive treatment during pregnancy (IPTp) • Strengthened capacity in malaria case management at health facility and community levels. • In partnership with the *Direction de l'Offre et de la Demande de Soins* (DODS), IHPB expanded iCCM in five health districts (Gahombo, Gashoho, Kirundo, Giteranyi, and Musema • Provided tools (registers, timers, stock cards, gloves, transfer and reference books) to CHWs • Intensified outreach activities and expanded communication materials (flipchart on malaria prevention) • Provided technical and logistical response to Malaria epidemic
Reproductive Health /Family Planning	• Strengthened health worker capacity in FP through training and supportive supervision • Trained CHWs in IHPB provinces to provide counseling on and offer FP commodities, including condoms and oral contraceptives • Provided injectable contraceptives in the community and referrals to HCs for long-acting and permanent methods (IUD, implants, tubal ligation and vasectomy). • Supervised household visits and quarterly and monthly meetings to monitor and ensure the quality of services and data reported from community activities
Maternal and Neonatal Health	• Provided ToT on basic emergency obstetric and neonatal care (BEmONC) for 27 health participants and on essential obstetric and neonatal care (EONC) for 14 participants • Produced existing job aids related to BEmONC for all health facilities in Kayanza, and provided formative supervision for MNH-related activities in all targeted provinces • Equipped Ngozi Nursing School to become a training center on obstetric and neonatal care • Conducted maternal death audits to analyze causes and use results for improvements • Continued to coordinate with other MNH partners and the MPHFA
Child Health	• Immunization surveillance by CHWs in Karusi and Muyinga provinces • Supported national mother/child week and African vaccination week activities • Trained and mentored CHWs on community-based management of acute malnutrition including malnutrition screening, referral, and nutritional education • Training health care providers in Karusi and Kirundo and supervising them on the clinical IMCI approach • Trained and mentored CHWs in Karusi and Kirundo on promotion of seven key behaviors

Y4 Progress and Discussion on HIV/AIDS Result Indicators

In Y4, IHPB continued supporting priority provinces to achieve 90-90-90 targets and ambitious COP17 aims through proven strategies, including index testing, outreach testing, diverse HIV testing modalities, supervisions, and transportation of DBS/PCR and VL samples and their results as well.

Table 14: Y4 Progress and Discussion on HIV/AIDS Results Indicators

PEPFAR Indicators	Target FY 2017	Achievement					
		Q1	Q2	Q3	Q4	Total	% Achieved
Number of individuals who received HTC services and their test results	155,008	86,447	83,385	72,822	72,955	315,609	203.6%
Number of HIV positive individuals	2,813	1189	1272	742	598	3,801	135%
Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	666	200	238	158	161	757	115.5%
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	666	161	299	57	73	590	88.5%
Number of people receiving post-GBV care	110	44	24	22	53	143	130%
Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load	2,813	918	984	663	444	3009	107%
Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	10,212	8712	8,911	8,972	8,646	8,646	84.6%
Number of adults and children newly enrolled on ART	2,725	1,114	1,047	647	426	3,249	113,4%
Number of adults and children receiving ART [current] (TA-only)	9,195	7,271	8,318	8,604	8,392	8,392	91,2%

PEPFAR Indicators	Target FY 2017	Achievement					
		Q1	Q2	Q3	Q4	Total	% Achieved
Number of PLHIV followed up screened for tuberculosis (TB_SCREEN)	8,646	4,603	4,798	5,594	6,619	6,619	76.5%
Number of registered new and relapsed TB cases with documented HIV status, during the reporting period (TB_STAT)	852	205	158	210	184	757	89%
Number of patients with tuberculosis enrolled on ART (TB_ART)	68	17	9	9	3	38	56%

AGGREGATE RESULTS

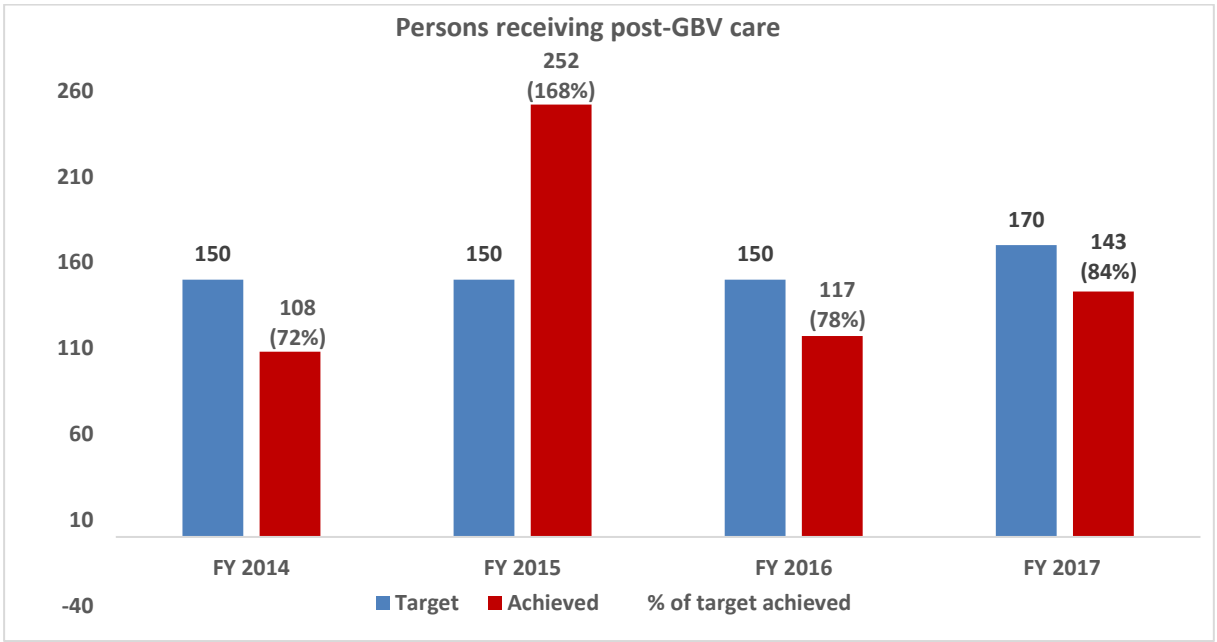
Across Kayanza and Kirundo provinces, IHPB exceeded FY 17 targets for the number of HIV cases diagnosed (135% of PEPFAR COP16 goal achieved as of September 30, 2017), number of HIV positive pregnant women receiving ARV to reduce the risk of mother-to-child transmission (115% of PEPFAR target achieved by the end of Y4), number of HIV-positive adults and children newly enrolled in clinical care (107% of PEPFAR target achieved by the end of Y4) as well as the number of adults and children newly enrolled on ART (113% of PEPFAR goal achieved by the end of Y4).

2. Progress and discussions on HIV/AIDS indicators

This section states the progress on HIV indicators in IHPB to the Performance Monitoring and Evaluation Plan (PMEP).

Indicator 1.3.4: Number of persons receiving post-GBV care (PEP, Post-rape care, other post-GBV care) [GEND_GBV]

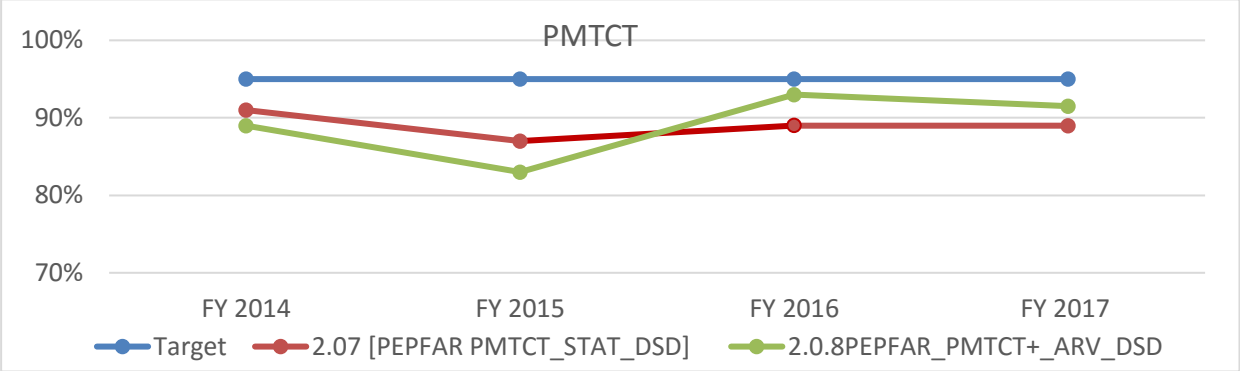
Figure 17 Number of persons receiving post-GBV care (PEP, Post-rape care, other post-GBV care) [GEND_GBV]



Indicator 2.0.7 & 2.0.8: Percent of pregnant women with known status [PEPFAR PMTCT_STAT_DSD] and Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV_DSD]

The proportions for both pregnant women knowing their HIV status and pregnant women who received antiretroviral to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery are still under expectations over the fiscal years.

Figure 18 Percent of pregnant women with known status [PEPFAR PMTCT_STAT_DSD] and Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV_DSD]

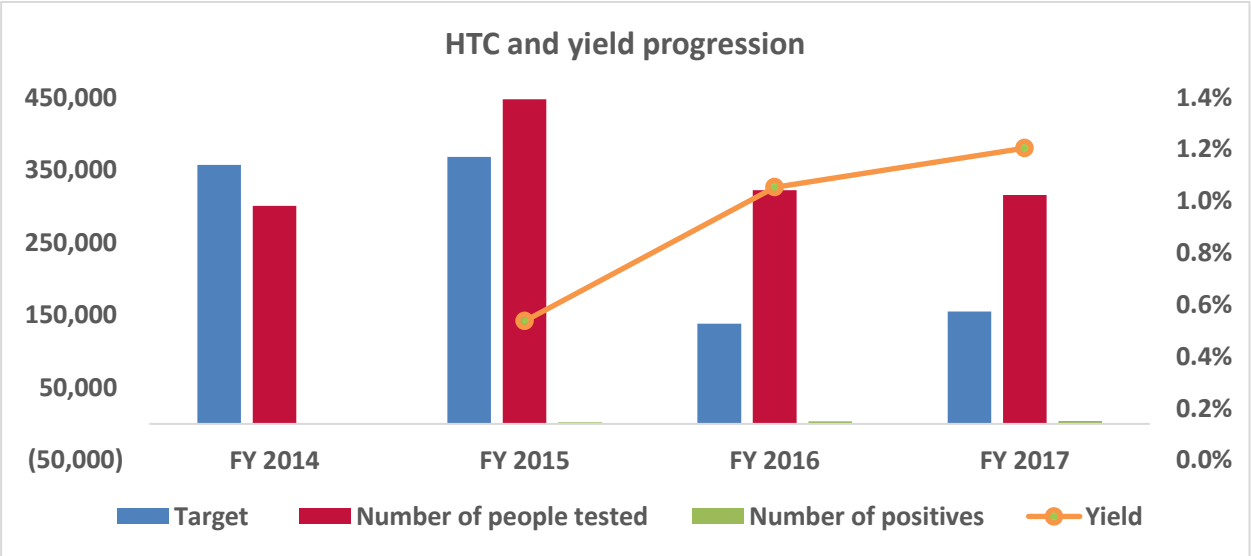


The lack of support by their partners and social discrimination results in refusing HIV test and or ARVs taking. Intensifying HIV awareness among partners is one of the strategies to enhance acceptance of HIV testing and ARV prophylaxis among pregnant women.

Indicator 2.0.9: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST_DSD]

We have overall good utilization of HIV testing and counseling services – each FY targets have been overachieved- thanks to provider-initiated HIV testing and counseling. However, positivity rate was less than the national prevalence of HIV (0.5% vs 1.3%).

Figure 19: Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST_DSD]

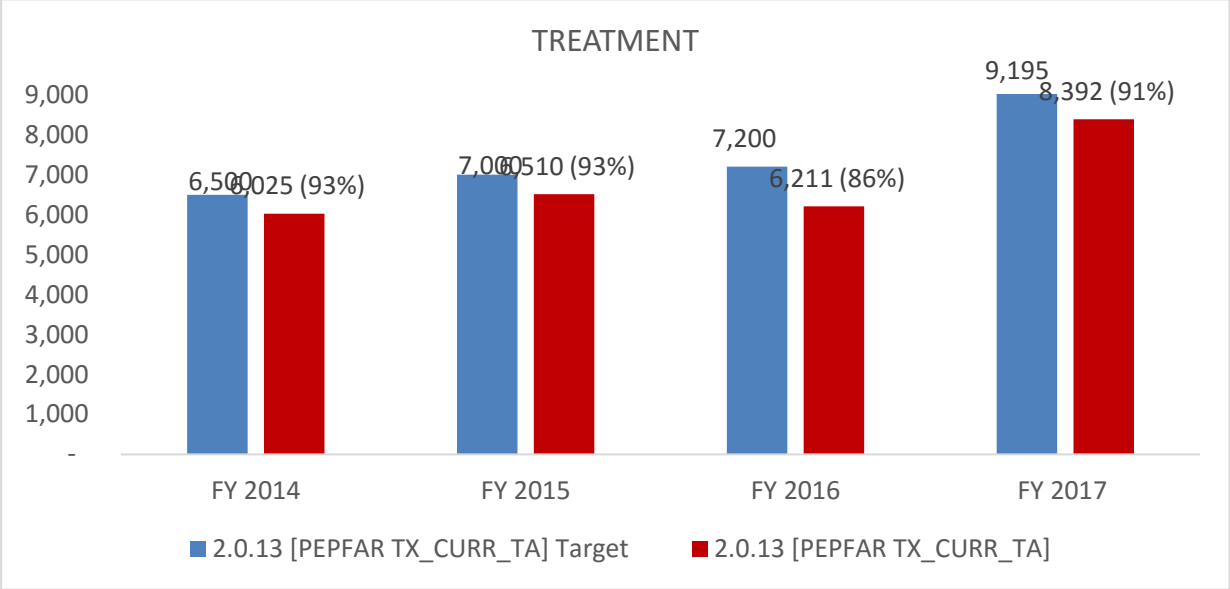


As of FY 2016, IHPB is focusing on testing of people at high risk of HIV infection /transmission targeting PLHIV family members and priority populations. As a result, the testing yield has increased from 0.5% (2015) to 1.2% (2017). It is an effective strategy to achieve the 90, 90, 90 objectives by 2020.

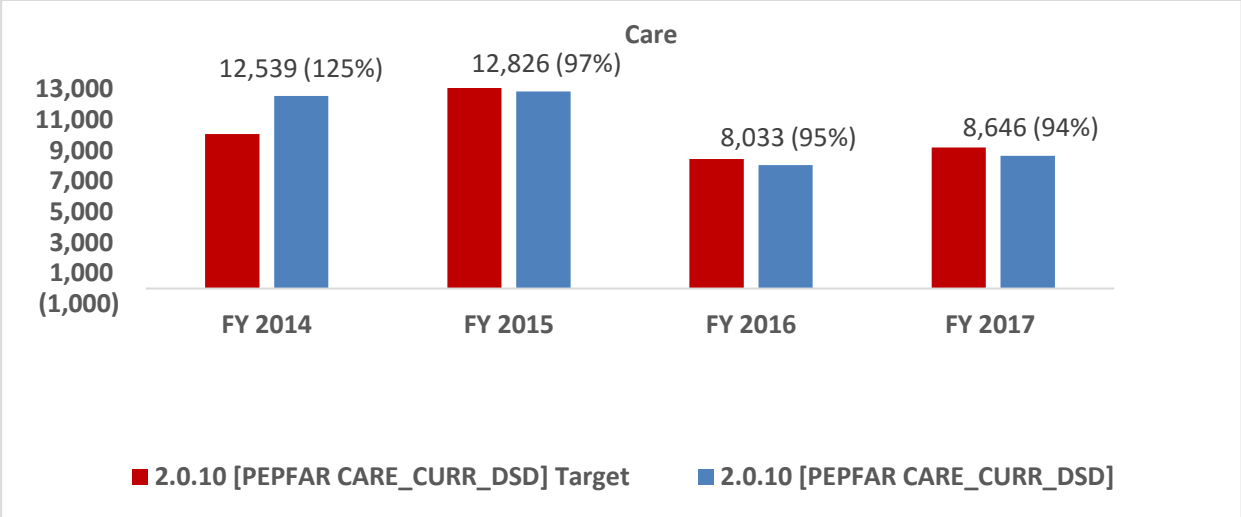
Indicator 2.0.10 and 2.0.13: Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD] and Number of adults and children receiving ART (TA only) [PEPFAR TX_CURR_TA]

Figure 20: Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD] and Number of adults and children receiving ART (TA only) [PEPFAR TX_CU

The indicators are related to care and treatment services. According to national guidelines -adopted in 2016, ART is initiated to every individual tested HIV positive regardless the number of CD4 counts. Achievements against targets are presented in the figures below:

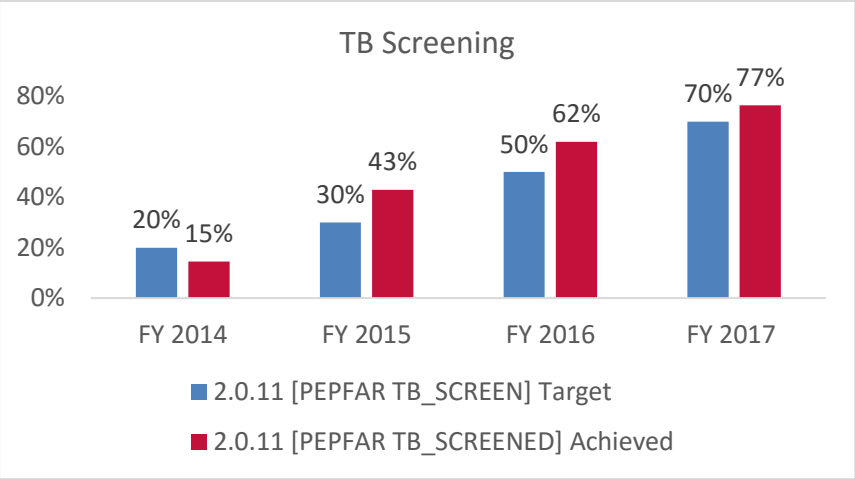


Strategies such as HTC services focused on individual at high risk of HIV in mobile and static HTC approaches as well as mentoring health centers and performing task shifting for antiretroviral therapy are responsible for the success.



Indicator 2.0.11: Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]

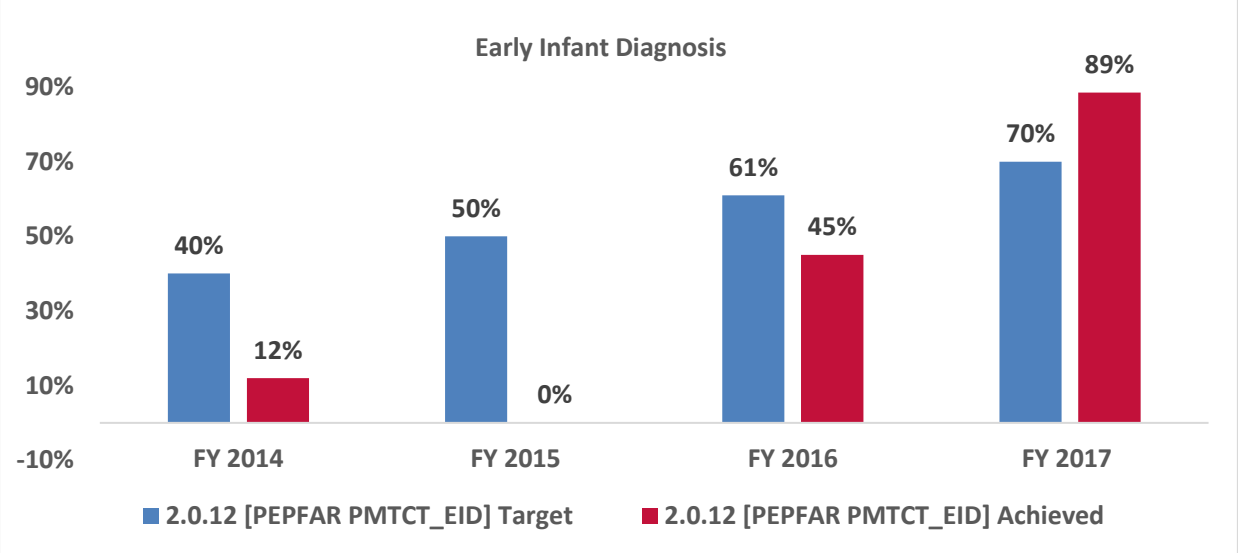
Figure 21: Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]



IHPB supports increased screening TB symptoms awareness of health providers in ART sites. And the number of PLHIV in HIV clinical care screened for TB symptoms at the last clinical visit has exceeded the target. Achievement of the target is thanks to regular health providers supervision

2.0.12 Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth [PEPFAR PMTCT_EID]

Figure 22: Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth [PEPFAR PMTCT_EID]



Poor outcomes for Year 1 & 2 are mainly due to the PCR machines recurrent breakdowns and reagent stock out. Contracting a private laboratory when public machine is not functioning allowed good performances in EID coverage.

Y4 Progress and Discussion on Malaria Result Indicators

Table 15: Y4 Progress and Discussion on Malaria Result Indicators

Indicator	Target FY2017	Achieved FY 2017				
		Q1	Q2	Q3	Q4[19]	Total
Percent of children under one year who had received LLINs through USG funds	97%	62% (16,165/ 25,950)	88% (24,022/ 27,423)	88% (18,254/ 20,652)	93% (11,535/12,430)	80% (68,976/86,455)
Percent of pregnant women who had received LLINs during ANC through USG funds	96%	60% (20,409/ 34,252)	82% (26,025/ 31,670)	81% (20,900/ 25,883)	86% (13,499/15661)	75% (80,833/107,466)
Percent of children under five with fever who received ACT within 24 hours of onset of fever	75%	75% (38,975/ 51,707)	79% (51,839/ 65,250)	72% (33,481/ 46,276)	78% (26,450/33,955)	76% (150,745/197,188)
Percent of pregnant women received IPTp 2 during ANC visits	70%	84% (18,378/ 21,769)	84% (20,455/ 24,383)	84% (17,557/ 20,978)	88,7% (10,863/12,299)	85% (67,253/79,429)

During Y4, IHPB partnered with the National Malaria Control Program (NMCP) and Direction de l'Offre et de la Demande des Soins (DODS) to support a comprehensive strategy to fight Burundi's malaria epidemic that includes a mix of service provider capacity building at facility and community level interventions (integrated community case management (iCCM)/community case management of malaria, IPTp, bed net distribution reporting, etc.), population awareness and empowerment (use of bed nets and SP and immediate care if fever), procurement of equipment for iCCM/CCM of malaria and developing health district micro-plans for the malaria epidemic response.

Provided technical and financial support during malaria epidemic period

Burundi continues to face a disproportionately high burden of malaria, with an incidence rate ranging from 80-100%. In 2015, 5,372,164 cases were recorded. Per 2016 data from the National Health Information System, this number increased dramatically to 8,836,134 positive reported cases and to 3,212,980 cases during the period February – March 2017. Seasonal malaria cases surpassed the epidemic level from mid-April 2016 to [when???] in three IHPB provinces (Kirundo, Muyinga, and Karusi). Some health centers in these provinces were overwhelmed by malaria cases, requiring IHPB to establish temporary outreach sites for malaria diagnostic and treatment, as well as mobile clinics.

Thus, as a part of malaria epidemic response, IHPB collaborated with the National Malaria Control Program (PNILP) to help health districts develop micro-plans for malaria epidemic response. Outreach activities for malaria treatment at outreach sites were conducted with administrative and religious leaders learning about their roles in malaria prevention in project workshops on the burden of malaria.

To support malaria prevention efforts, IHPB developed and distributed communication material to CHWs that include 3,422 flipcharts on malaria and 3,500 laminated copies on use and maintenance of LLINs. With interactive community theater, led by local drama groups, 51,362 people were reached by malaria messages **(**use of bed nets and SP, and immediate care if fever).

The project also participated in a mass distribution campaign of LLINs from September 18-23th, 2017 at the district level by providing its vehicles for LLINs transportation from health facility to temporary sites of malaria treatment.

[19] Data for September will be available at the end of October.

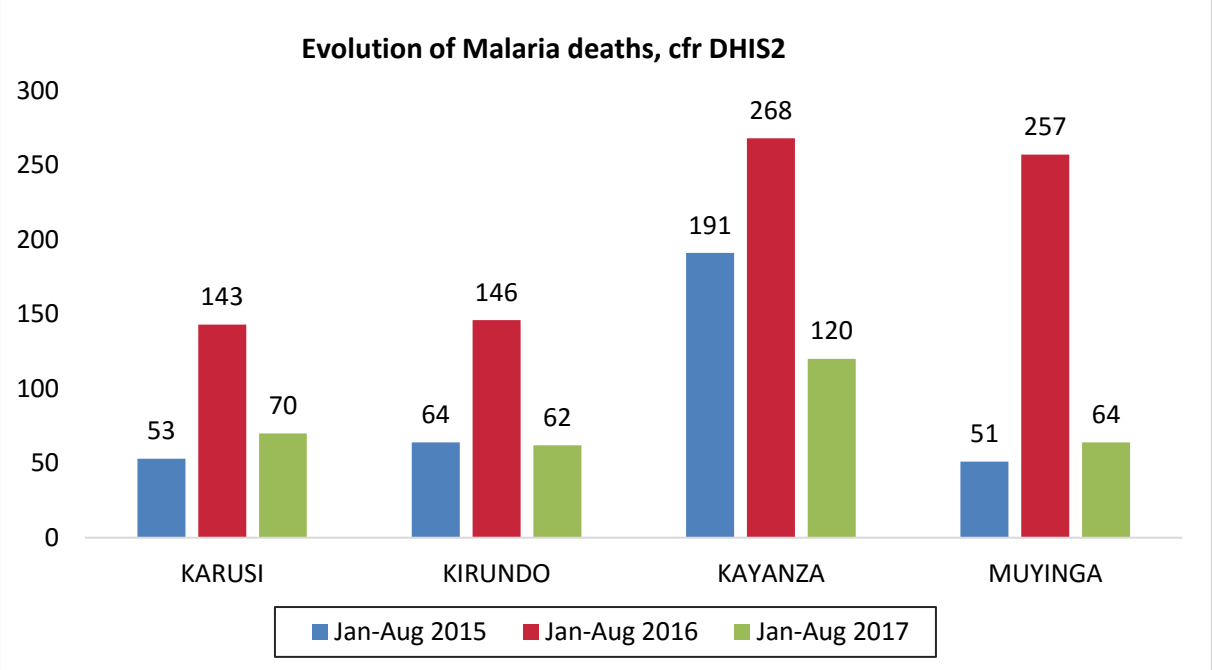
The table below shows the number of persons with fever who received treatment for malaria at temporary sites for malaria diagnostic and treatment.

Table 16: Number of persons with fever who received treatment for malaria at temporary sites for malaria diagnostic and treatment

Province	Suspected cases (with fever)	Rapid diagnostic Test (RDT) positive	Treated		
			Children under 5 years	Pregnant women	Over 5 years
Kayanza	79,549	56,036	14,233	439	41,364
Karusi	26,253	22,097	12,803	2,072	7,222
Kirundo	71,701	66,851	14,875	334	51,642
Muyinga	13,829	9,928	2,664	11	7,253
TOTAL	**191,332**	**154,912**	**44,575**	**2,856**	**107,481**

With population awareness and empowerment activities, as well as mobile clinics during the malaria epidemic period, a significant reduction in malaria-related deaths was achieved in 2017. Per data extracted from DHIS2, the graphic below shows an average 61% reduction in malaria-related deaths across project provinces in 2017 compared to 2015 and 2016 (the period of January to August is considered for the three years).

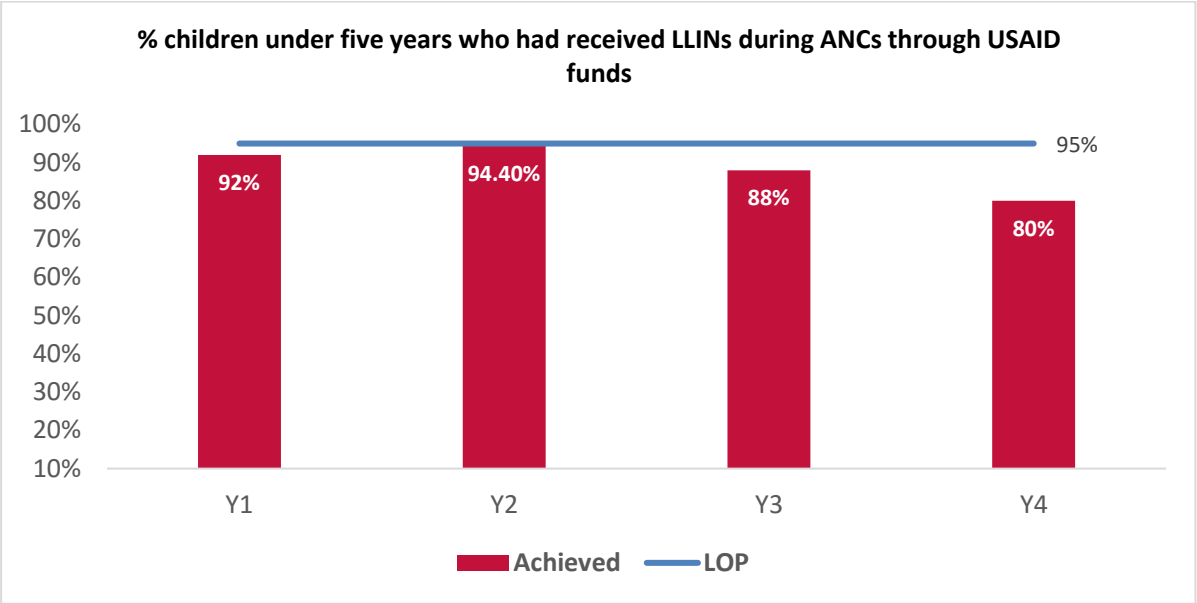
Figure 23: Evolution of Malaria deaths, cfr DHIS2



Percent of children under one year who had received LLINs through USG funds

As reflected in the chart below, 80% of the LOP target was achieved by August 2017. A major stockout of LLINs at the central level occurred in October 2016 and lasted 2 months limiting the achievement of this indicator. However, supervision visits and sensitization sessions for mothers with children under one year for measles immunization contributed to increasing the indicator during Y4. IHPB is responsible for awareness related to preventing and fighting malaria by promoting use of LLINs at household level and supporting their distribution and integration with other services (for example, ANC).

Figure 24: % children under five years who had received LLINs during ANCs through USAID funds

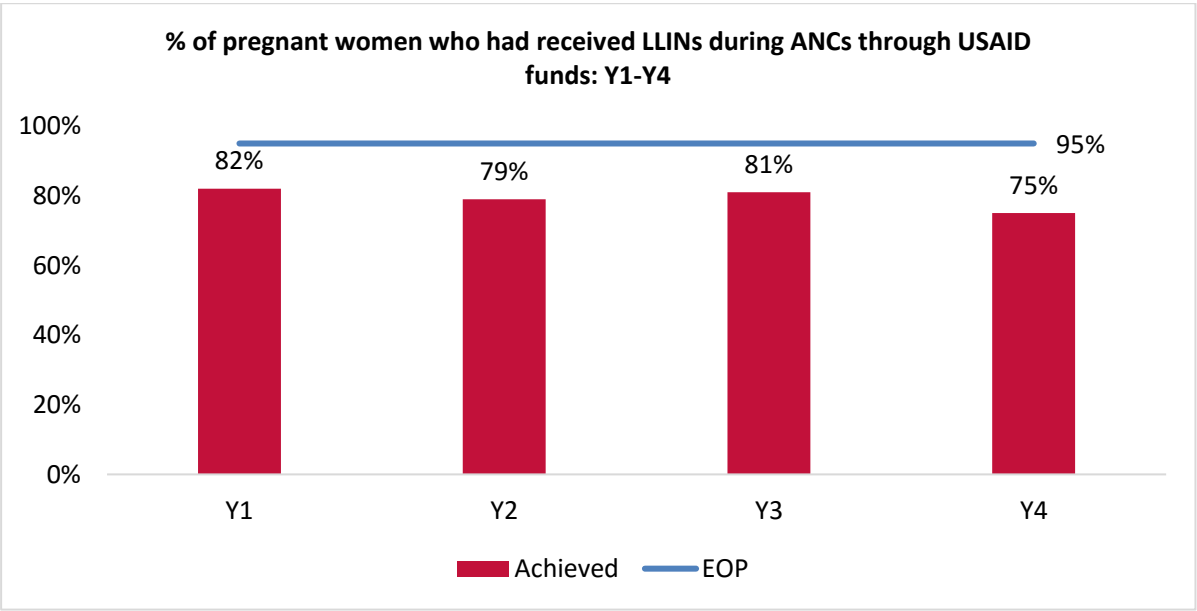


Percent of pregnant women who had received LLINs during ANC through USG funds

Challenges in achievement of this indicator are based on stock out of LLINs at central level that occurred in October 2016 and that lasted 2 months. As indicated in the scheme of LLIN distribution, pregnant women seeking their first ANC visit outside their health center could not receive a LLIN. However, coaching visits at the facility level, as part of quality improvement of health services, contributed to increased performance of this indicator.

The graph below shows progress from the beginning (Y1) till now (Y4).

Figure 25: % of pregnant women who had received LLINs during ANCs through USAID funds: Y1-Y4

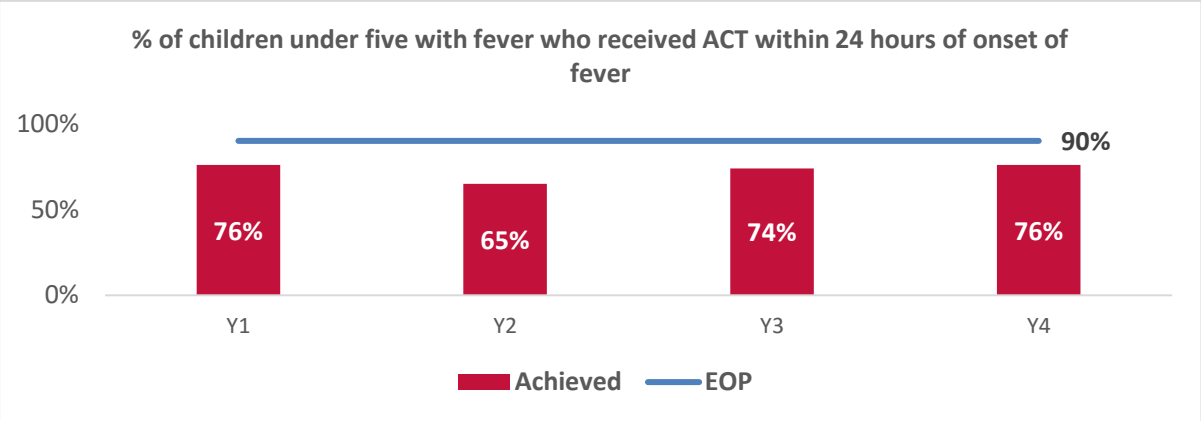


P*ercent of children under five with fever who received ACT within 24 hours of onset of fever*

The project partnered with NMCP, DODS and the district health bureau to conduct training of trainers' sessions on iCCM for 138 health care workers, who in turn conducted training sessions for 622 community health workers[20] (CHWs) and distributed equipment[21] at the closure of training sessions. To further support iCCM implementation, IHPB partnered with health workers and health district supervisors to conduct supportive supervision visits to all 622 CHWs at the household level. IHPB also supported and conducted quarterly meetings at the communal level for sharing experience on community activities and resolving challenges. Five districts (Gahombo, Gashoho, Giteranyi, Kirundo and Musema) are implementing community case management of malaria/iCCM.

The table below shows the progress of the indicator from the beginning of the project.

Figure 26: % of children under five with fever who received ACT within 24 hours of onset of fever



Stocks out of malaria commodities at community level, due to underand overconsumption of malaria commodities at health center level (ACT, RDT) during malaria epidemic period, hampered the achievement of that indicator.

Percent of pregnant women received IPTp 2 during ANC visits

The project conducted training sessions on IPTp for an additional[22] [number] health care worker per health facility. Thus, 208 health care workers, trained as trainers, conducted training sessions on IPTp to 3,291 CHWs for raising community awareness on IPTp adoption, followed by distribution of leaflet on IPTp during trainings: 3,410 leaflets were distributed. To ensure correct implementation of the strategy, IHPB collaborated with health district supervisors to conduct a joint supportive supervision within 129 out of 183 health centers (73% of health centers visited) using the OASIS[23] tool. Using leaflets developed by the project, sensitization sessions conducted by CHWs and health promotion technicians (HPT) contributed to the performance of that strategy.

In Year 4, 84% of pregnant women received IPTp2 during ANC visits, exceeding the annual target of 70%. The graph below shows the evolution of this strategy from the beginning of its implementation in 2015 comparing to the target at the end of the project.

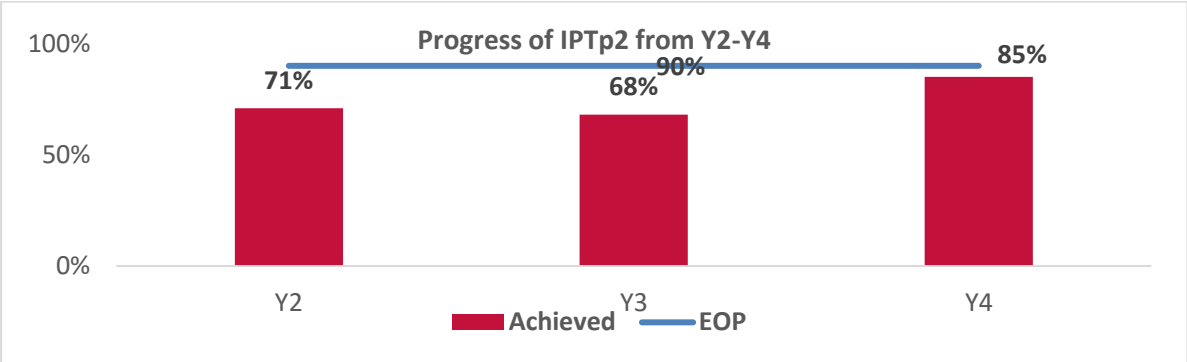
[20] iCCM strategy is composed of 3 modules: malaria, diarrhea and pneumonia that are taught to CHWs separately.

[21] iCCM equipment: Individual tracking record for the sick child, register of cases, transfer book, requisition cards, stock cards, taking algorithm managed at home with diarrhea, taking algorithm managed at home with pneumonia, ICCM book, safety box, garbage can, electronics timer, gloves, solar lamps

[22] One health care worker per health center has been trained in Y2.

[23]OASIS : Outils intégré d'Amélioration des Services de Santé ; developed by IHPB.

Figure 27: Progress of IPTp2 from Y2-Y4



Y4 Progress and Discussion on RH/FP Result Indicators

Table 17: Y4 Progress and Discussion on Rh/FP Indicators

Indicator	Target FY 2017	Contribution of each method to couple years' protection				
		Q 1	Q 2	Q 3	Q 4[24]	Total
2.0.1. Couple Years Protection in USG supported programs (USAID 3.1.7.1-1)	153,795					186,263.6
Pills		25,235	35,331	34,322	23,744	118,632
Injectable		53,633	54,855	60,280	39,686	208,454
Male Condom		50,005	87,989	102,967	84,049	325,010
Female Condom		639	3,543	3,157	2,982	10,321
IUD		949	992	1,694	741	4,376
Implant (Jadelle)		5,778	6,654	9,667	5,579	27,678
Male sterilization		125	135	330	62	652
Female sterilization		101	70	110	127	408
2.2.2. Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (USAID 3.1.7.1-3)	75%	82%	150/183 (82%)	154/183 (84,1%)	154/183 (84,1%)	154/183 (84.1%)

The most recent Burundi Demographic and Health Survey (DHS) revealed modest decreases in total fertility and the proportion of adolescents with sexual activity and modest increase in the number of clients newly accepting FP. These trends track with IHPB implementation. While implementing planned activities, IHPB sought to monitor and control compliance to USG FP regulations in health facilities under IHPB Support. 147 Health facilities were visited by IHPB technical staff and monitored using a French-language questionnaire.

2.0.1. Couple Years Protection (CYP) in USG supported programs

As indicated in the graphic below, by the end of August 2017, with a total of 186,263 CYP, IHPB exceeded its year four target of 153,795 and approached the EOP target of 195,561. In addition, as reflected below,IHPB approached or exceeded annual targets for CYP in year one. Burundi's political crises hampered efforts in year two, but the project worked intensively to overcome inaccurate rumors about long-acting family planning methods and to improve contraceptive uptake in year three and year four.

[24] Data for September is not available.

IHPB enhanced the community systems supporting family planning access and use by strengthening community health workers capacity to counsel on, offer and provide FP methods including condoms and pills; re-energized the networking committee for 251 members from 9 youth friendly health centers' catchment areas to address rumors relating to use of FP methods by youth and adolescents; train 112 young pupils as peers educators on youth and adolescent sexual and reproductive health; and conducted awareness activities through 17 sessions using theater groups at the community level.

The graphs below show us their main contribution to Couple Year Protection. Karusi and Kayanza are the provinces which have most improved their couple year protection from year one to year four as indicated in graphic (figure 1) below. Muyinga has not seemed to progress, but this is because the community health workers (CHWs) from Gashoho health district (one of the three health districts in the province) have not distributed or provided good counseling on family planning commodities. The CHWs have not been trained on CBD activities. A training session is scheduled for the CHWs in November of Year 5.

Figure 28: Contribution of each method to CYP

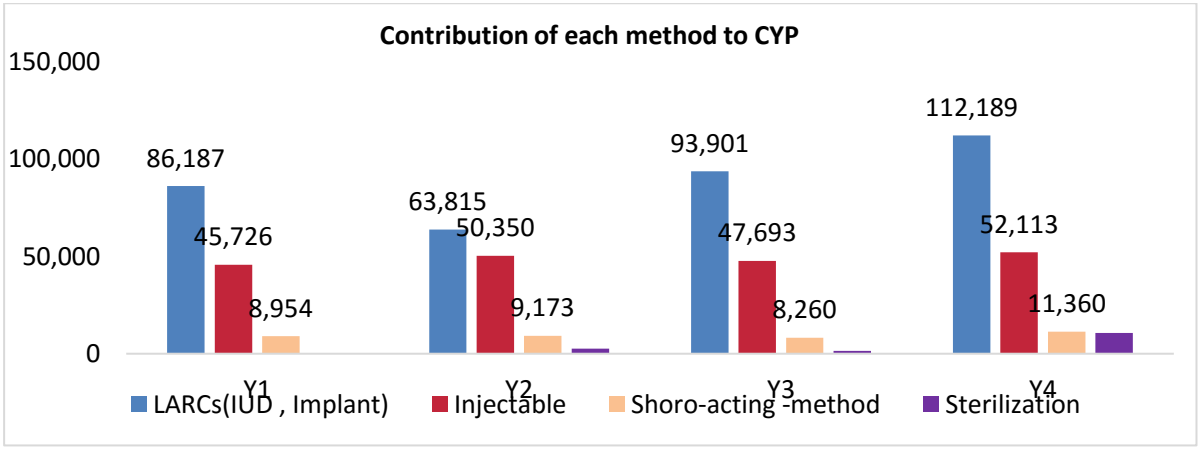


Figure 29: CYP progress in supported PROVINCES FROM y1 to y4

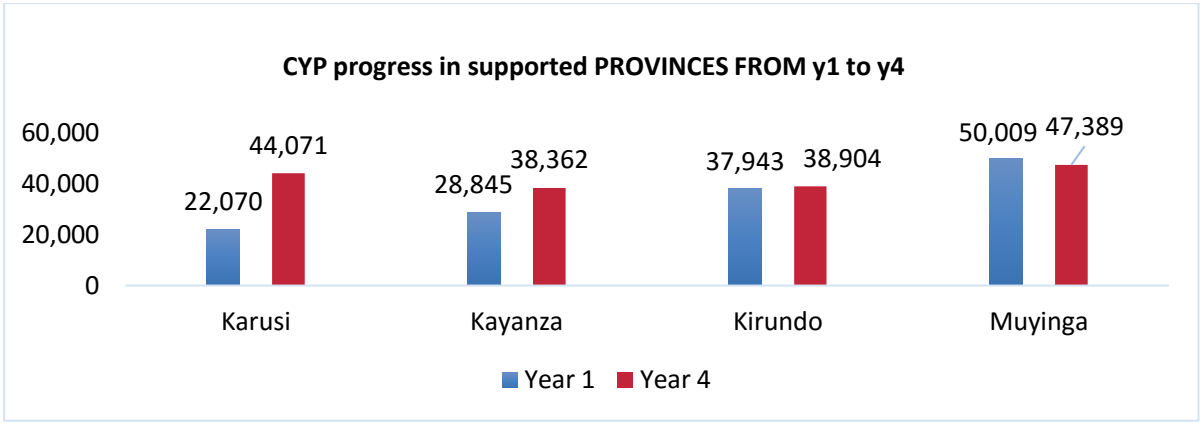
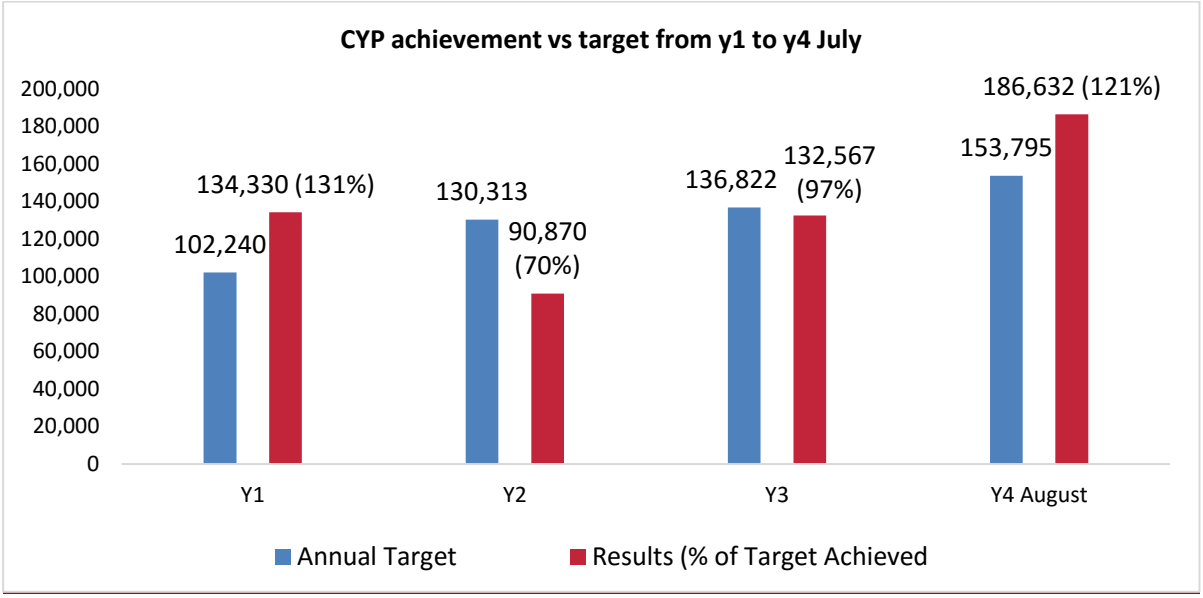


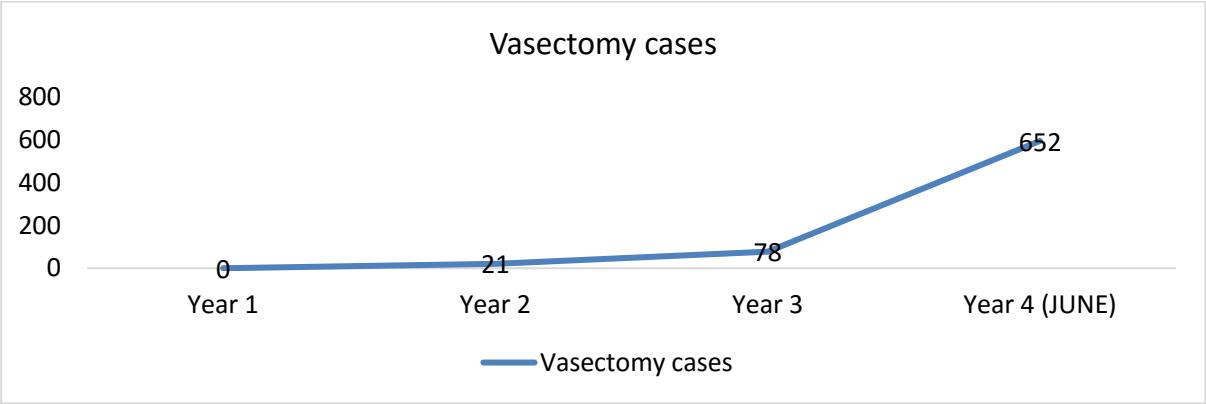
Figure 30: CYP achievement vs target from y1 to y4 July



To achieve the year four CYP targets, IHPB sought to strengthen health worker's capacity in FP through training (specifically in vasectomy), supportive supervision and training CHWs to provide counseling on FP commodities as well as offering services. HPTs and CHWs provided condoms, oral contraceptives and injectable contraceptives in the community. They also made referrals to HCs for long-acting, permanent methods (IUD, implants, tubal ligation and vasectomy), and integrated family planning outreach activities into the program.

Training on Non-Scalpel Vasectomy:
IHPB supported the training of 11 medical doctors and 11 operation room nurses who acquired skills in performing non-scalpel vasectomies. As results from the trainings, vasectomies cases increased dramatically, with 652 registered vasectomy clients recorded between October 2016 and July 2017 in IHPB-supported districts – while cases increased from only 21 vasectomy clients in Year 2 and 78 in Year 3. The graphic below illustrates the cumulative number of vasectomies performed in IHPB-supported hospitals by each year.

VASECTOMY ACHIEVEMENT
Figure 31: Trends of Vasectomy cases



Trained 2,049 CHWs to offer and provide counseling on FP commodities, including condoms and oral contraceptives
In year four, 2,049 CHWs were trained to offer and provide counseling on FP commodities, including condoms and oral contraceptives in eight health districts compared to the 469 CHWs that were trained in

year three. After receiving the kits (Umbrella, bag for commodities transportation, FP manual in Kirundi language, and flip chart), the CHWs were very successful in their work of raising awareness on FP activities through sensitization meetings, household visits, and distributing FP commodities at the community level. The injectable contraceptives in the community were provided by health promotion technicians who promoted and counseled on the use of long-acting and permanent methods of contraception such as the IUD, implants, tubal ligation and having a vasectomy. Health promotion technicians referred acceptors of those methods to the health centers.

Table 18: Raising awareness activities conducted

Raising awareness activities conducted	Year 3 (469 CHWs)	Year 4 (October 2016 – August 2017) (2,049 CHWs)
Households visited	32,732	177,413
#People reached by FP message	126,421	869,571
FP commodities distributed		
Condoms	48,188	435,591
Pills	821	15,583
People referred to health facilities for long acting and permanent contraception	1,907	11,597

Supervised household visits and quarterly/monthly meetings to monitor and ensure the quality of services and data reported from community activities

All the strategies were implemented at the community level to strengthen the community based distribution of contraceptives. 66 low-performing CHWs in CBD were supervised during their household visits and during their FP commodities distributions to improve their work.

Five quarterly meetings and three-monthly meetings were held at the communal level with CHWs involved in community based distributions of contraceptives to ensure the quality of services delivered by CHWs and data reported from community activities

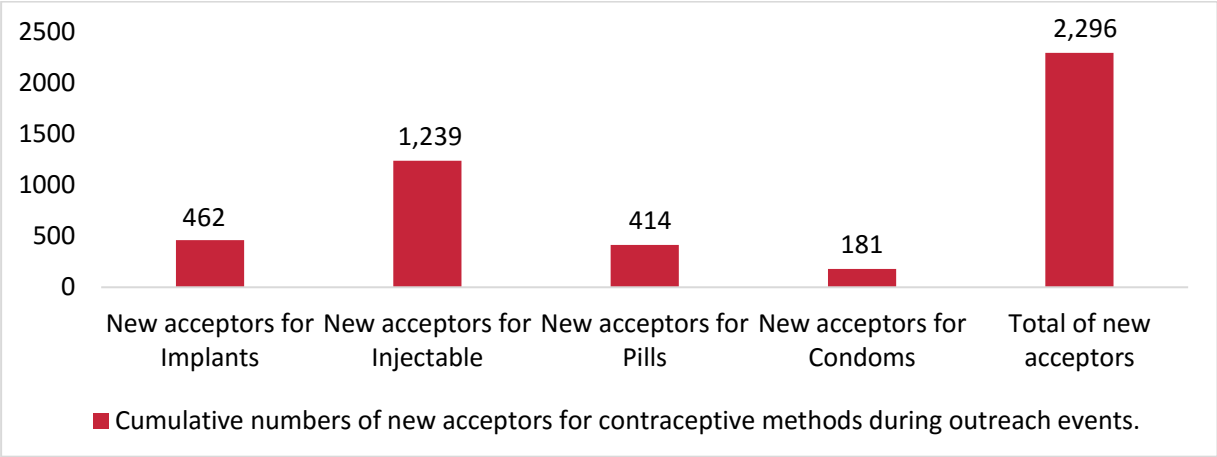
Integrated mobile outreach strategy and raising awareness by theater group

To increase access to contraceptive methods and health services, IHPB in partnership with the health district and the health province authorities organized integrated mobile outreach events with underserved areas. The activities combined both counseling and delivery methods at the site level. The counseling was sustained through awareness sessions by the theater groups which were conducted to address rumors affecting long-acting and short-term family planning methods. A total of 103 sites were visited with integrated outreach mobile activities reaching 16,495 people.

Condoms are not provided through this strategy as condoms are most commonly distributed by CHWs at the community level. This strategy proves to be a successful mechanism for distribution of injectables - LARCs (implants) are delivered through the integrated outreach strategy provided at the community level by health providers.

The graphic below shows the cumulative number of new acceptors receiving commodities within sites visited during the sessions at the community level:

Figure 32: Cumulative number of new acceptors for contraceptive methods during outreach events

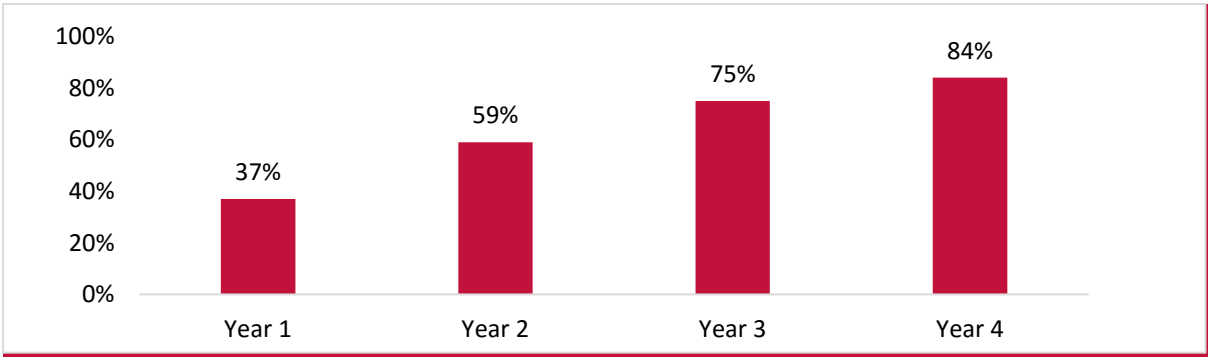


2.2.2. Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services

This indicator considers health facilities that counsel on FP methods and/or distribute methods. We include faith-based facilities as the denominator, though these facilities do not offer modern FP methods. Based on June's achievements, 84.4% of supported facilities (public, private, and faith-based) delivered counseling and/or contraceptive methods. Note that 100% of public health facilities counsel on and distribute family planning methods.

Comparing Year 1 to Year 3, Figure 4 shows the evolution of the indicator below:

Figure 33: Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services



Y4 Progress and Discussion on MNH Result Indicators

Table 19: Y4 Progress and Discussion on MNH Result Indicators

Indicator	Target FY2017	Achieved FY 2017				
		Q 1	Q 2	Q 3	Q 4	Total
2.0.5. Number/percentage of women giving birth who receive uterotonics in the third stage of labor through USG-supported programs	80%	91% (17,894/ 19,627)	97% (21,826/ 22,429)	87% (21,724/ 24,942)	91% (17,872/ 19,628)	92% (80,029/ 87,453)
Number of people trained in maternal/newborn health through Burundi MCH supported programs	69	59	0	0	15	74/69 (107%)
Number of USG-supported facilities that provide appropriate life-saving maternity care (this will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC)	HC: 18.3% Hospitals:89%	N/A	N/A	N/A	N/A	N/A

In Burundi, rates of skilled birth attendance increased from 66% in 2010 to 85% in 2016[25]. This increase needs to be maintained through the availability of quality services provided by skilled health providers.

In Y4, the IHPB MNH activities focused on strengthening the capacity of the health system to increase the availability and quality of MNH services through training of trainers (ToT) on basic emergency obstetric and neonatal care (BEmONC) for 27 participants and a ToT on essential obstetric and neonatal care(EONC) for 15 participants. The project has produced existing BEmONC job aids for all health facilities in Kayanza, and has provided formative supervision for MNH-related activities in all targeted provinces. These activities have helped IHPB increase and exceed its annual target related to the use of uterotonics in the third stage of labor.

Number/percentage of women giving birth who received uterotonics in the third stage of labor through USG-supported programs

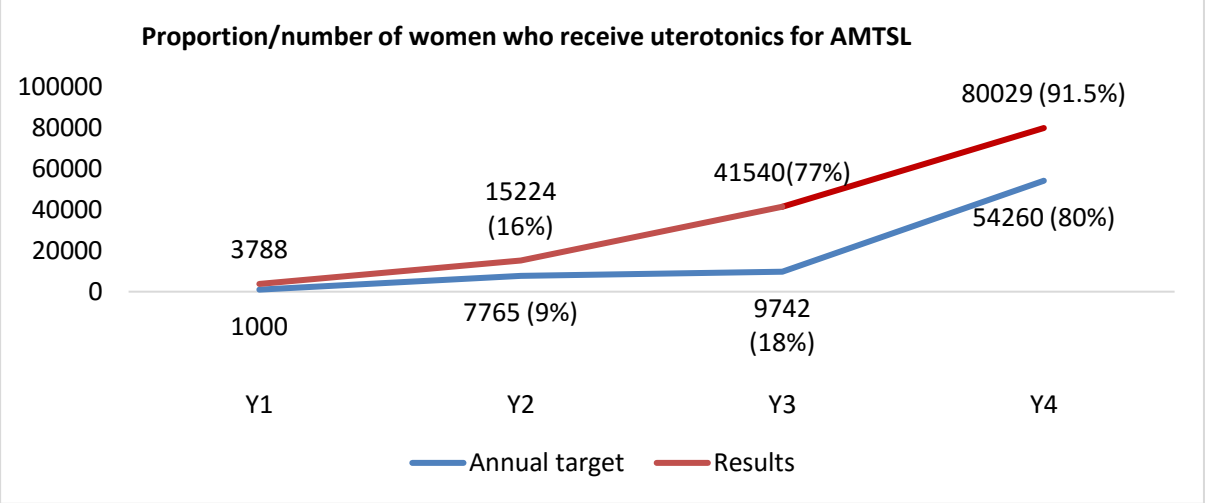
In Y4, a total of 80,029 women (92% of women who delivered in health facilities) received uterotonics during the third phase of labor to prevent postpartum hemorrhage.

There is a decrease from Q2 (97%) to Q3 (87%) due to the low supply of oxytocin reported in 23 health facilities (12% of the total number of health facilities), which is a result of oxytocin being out of stock from the district pharmacies. The district pharmacies have limited resources and have difficulty purchasing the necessary commodities due to the threshold of 5 million Burundi francs(BIF) for essential medicines for procurement in private pharmacies when there is a stock out in central pharmacy" central d'achat des medicaments du Burundi (CAMEBU)". For this challenging situation, some partners are supplying some strategic products through the specific programs such as UNFPA (United Nations Fund for Population Activities) through the reproductive health program: "Programme National de Santé de la Reproduction(PNSR)" for Oxytocin.

Over the life of the project there has been a steady increase in the number of women receiving uterotonics. IHPB has consistently surpassed its annual targets in this area, as show in the graph below. Considering there has been an increase in the number of women receiving uterotonics since the beginning of the project, and every year the target goal is exceeded as shown in the graph below:

[25] DHS 2016-2017

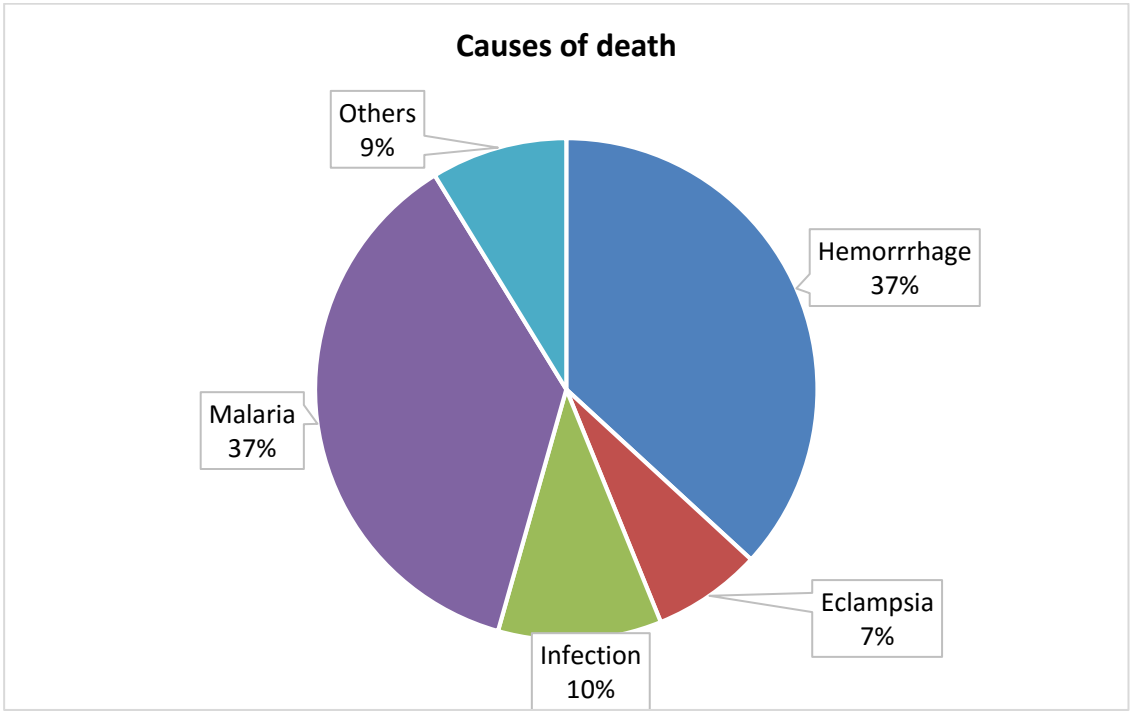
Figure 34: Proportion/number of women who receive uterotonics for AMTSL



This is a result of a series of activities including:

- Training on active management of third stage of labor (AMTSL) (every health facility has at least on health provider who has been trained). This year, 32 health workers from Vumbi (17) and Kirundo (15) were trained on AMTSL.
- Training on supply chain management (SCM) at district level and HF level by the SCM officer.
- Formative supervision for MNH-related activities in all target provinces and HF, and logistical support for commodities transportation from the central level to the health district.
- CHWs sensitization on danger signs during pregnancy was conducted by SBCC team.
- Maternal death audits: during Y4, 70 maternal deaths were reported and maternal death audits were organized for 81% of maternal death (57 out of 70 maternal deaths) that were reported in 10 hospitals of target provinces. Results from the audits show that there are two main causes of death: malaria (37%) and post-partum hemorrhage (37%) as shown in the chart below.
-

Figure 35: Causes of death



The project works to address these main causes through training on post-partum hemorrhage prevention, AMTSL training and the malaria strategy set up mobile clinic for malaria case management. The project also ensures that intermittent preventive treatment during pregnancy (IPTp) is offered to pregnant women in all target provinces during antenatal care(ANC).

It was observed by the project that 61% of the deaths occurred in post-partum, 35% in antepartum and 4% of deaths occurred during delivery.

There is a need to strengthen the skills of the providers when using partographs for inpatient follow up, which will be addressed in Y5.

- *In Muyinga, every referral is accompanied by a nurse on board in the ambulance as recommended during maternal death audits*
- *In Kayanza, its was recommended that the medical doctor on duty must have the mobile phone used for referral to be reached at any time and facilitate referral case management*

Number of people trained in maternal /newborn health through Burundi MCH supported programs

In Y4, the project trained 74 health providers in MNH, exceeding the annual target of 69. These trainings included:

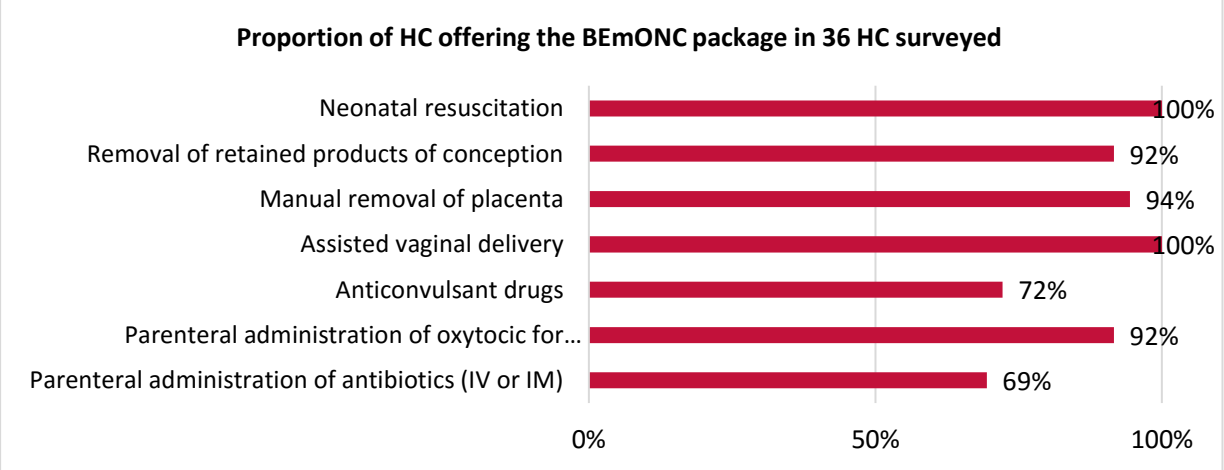
- Training of trainers on BEmONC: In partnership with the PNSR, IHPB organized two 10-day sessions of training on BEmONC for 27 participants from Muyinga (8), Karusi (6), Kayanza (5) and Kirundo (8).
- Training on AMTSL: In partnership with Vumbi and Kirundo health districts, IHPB trained 32 health workers from Vumbi (17) and Kirundo (15).
- Training of trainers on EONC: In partnership with the PNSR, IHPB organized two 10-day training of trainers on EONC for 15 health workers from Kayanza (7) and Kirundo (8).

While organizing trainings on EONC and BEmONC the project noted a lack of training centers in the country (there are only two BEmONC center and one EONC center) to cover all of the training needs. In response, IHPB equipped one training center in Ngozi. The support consisted of the acquisition of training materials for EONC and BEmONC for training centers, including anatomic models, chairs, tables, LCD, printer, projection screen, flowchart, childbirth kit and a vacuum extractor.

Number of USG-supported facilities that provide appropriate life-saving maternity care (defined as seven signal functions for BEmONC and nine signal functions for CEmONC)

The SARA conducted in 2014 by the project identified 38 health facilities in IHPB target provinces providing life-saving maternity care as defined by the seven signal functions for BEmONC and the nine functions for CEmONC. IHPB conducted training on BEmONC for a total of 86 health providers from 43 health facilities in Karusi, Kirundo, and Muyinga. In Year 3, a small survey of 36 targets health centers found that 42% (15) offer lifesaving maternity care as defined above.If we consider the package as defined by signal functions, the availability of services in health facilities is as in the graph below:

Figure 36: Proportion of HC offering the BEmONC package in 36 HC surveyed



2 out of the 7 signal functions (neonatal resuscitation and assisted vaginal delivery) are available in all HC and there are 2 services component of BEmONC lacking in many health centers: 72 % of health centers surveyed are providing anticonvulsant drugs and 69 % are providing parenteral antibiotics.
IHPB continues to conduct supervision for the 86 health providers trained to ensure that quality services are available. The endline survey planned in Y5 will better inform achievement on this indicator.

To achieve this indicator, several activities were conducted:

- Supervision on BEmONC to ensure quality services are available and provided
- Training of trainers on BEmONC
- Mentoring exercise on EmONC for physician and nurses to which IHPB brought support among other MPHFA's partners including World health organization(WHO) and UNFPA
- Producing existing job aids related to BEmONC for all health facilities in Kayanza

Y4 Progress and Discussion on Child Health Result Indicators

Table 20: Y4 Progress and Discussion on Child Health Result Indicators

Indicator	Target FY2017	Achieved FY 2017				
		Q 1	Q 2	Q 3	Q 4	Total
2.0.4. Number/percent of children who received PENTAVALENT3 by 12 months of age	103,333 (98%)	22,555 (21.6%)	21,574 (21%)	22,662 (21.7%)	18,232[26] (17.4%)	85,445 (81.3%)
2.0.6. Number/percent of women reached with education on exclusive breastfeeding	211,500	69,928	87,257	94,388	63,414[27]	317,783

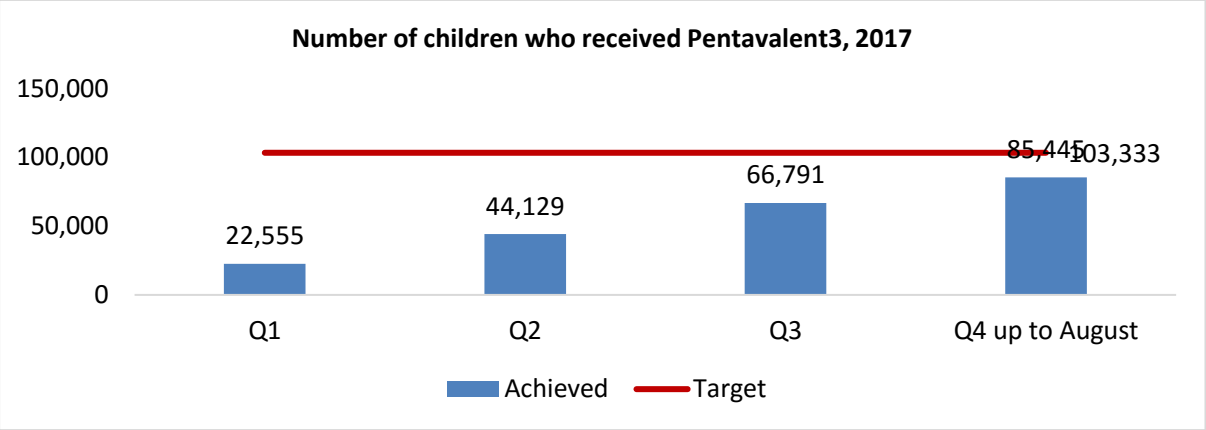
In child health area, IHPB works to strengthen three main components: immunization, nutrition, and care for childhood illness. During Y4, IHPB carried out several activities that include training of CHWs on community-based management of acute malnutrition; training of CHWs on the seven key best practices for child health; involvement of CHWs in active immunization surveillance; supervision of health centers on clinical IMCI implementation; improvement of CHWs' supervision; and improvement of the community health information system. These activities aimed to achieve the two indicators presented in the table above.

2.0.4 Number/percent of children who received Pentavalent3 by 12 months of age

With information extracted from the health centers' monthly reporting, the project found that up to August 2017, 85,445 children received Pentavalent 3, versus an annual target of 103,333 (98% of all children). This is 82.7% of the annual target, which represents 90% of the pro-rated target for eleven months. The annual target is not likely to be reached, due to diversion of health resources to the malaria epidemic that broke out in IHPB target provinces from December 2016. Due to the epidemic, preventive service demand decreased in health facilities, and the flow of children through immunization services decreased also. In addition, health services shifted their priority and the focus to the outbreak response; this made other health services suffer from the personnel shortage.

[26] Data for September 2017 not yet available
[27] Data for September 2017 not yet available

Figure 37: Number of children who received Pentavalent3, 2017



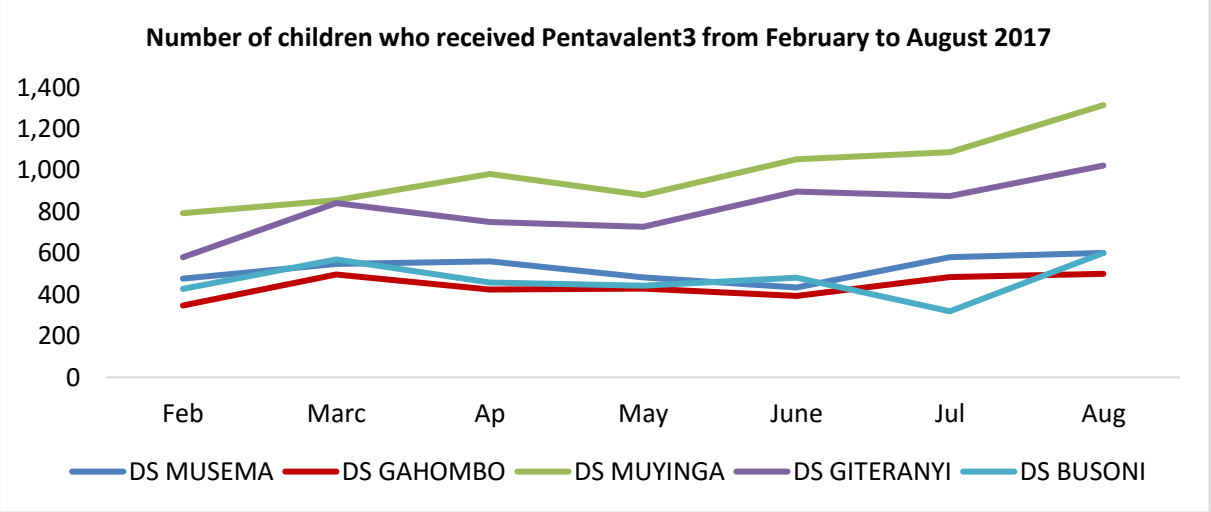
The various activities that were implemented to achieve this indicator are:

Involving CHWs in active immunization surveillance in Muyinga

This strategy was introduced in February 2017 in Muyinga. 806 CHWs were trained on the immunization schedule, with registries provided to them. They were trained on how to register every newborn and the dates he/she is expected to have different vaccines. This helped reduce the number of children who never start the immunization schedule and to catch up with those who are late or who intend to drop out. The graph below shows that two health districts implementing the strategy (Muyinga and Giteranyi) kept an upward pace of Pentavalent3 use since the strategy was introduced in February 2017. The situation is not the same for other health districts that are not implementing the strategy (Busoni, Gahombo, and Musema).

Based on the experience of Muyinga province, the immunization surveillance by CHWs will be initiated in Kirundo province during Y5.

Figure 38: Number of children who received Pentavalent3 from February to August 2017



Training CHWs from Kirundo and Mukenke health districts on the promotion of seven key best practices for child health

The seven key best practices for child health include the promotion of children immunization. 431 CHWs from Kirundo and Mukenke were trained on the module, covering the 12 health districts of IHPB. In addition, a booklet on the seven practices was provided to the every CHW from the four IHPB provinces.

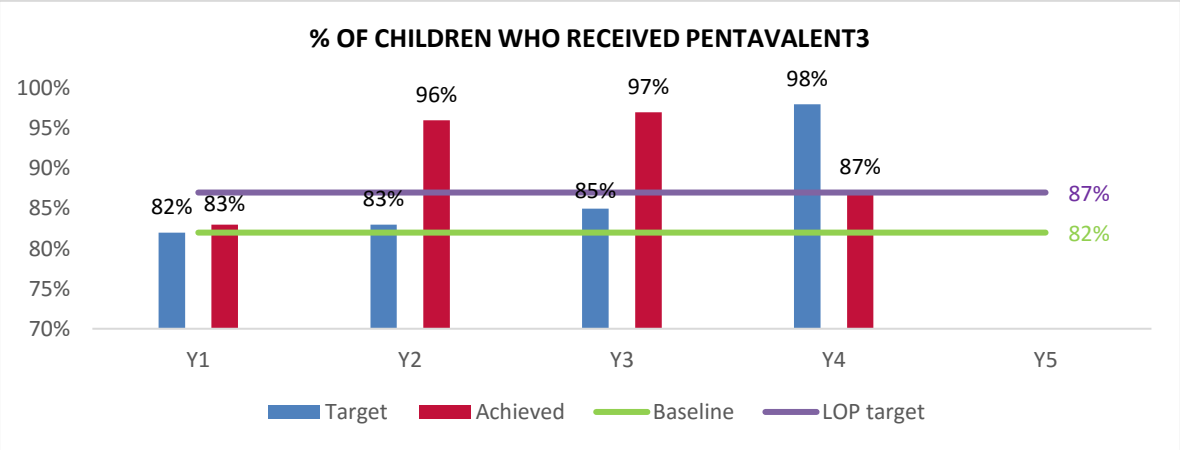
Supervision of clinical IMCI implementation

Integrated management of childhood illnesses (IMCI) covers all child health components, including systematically verifying immunization status. This helps to vaccinate every child who comes for care. During Y2 and Y3, 90 health care providers were trained on the strategy. During Y4, a two-round supervisory visit was conducted to strengthen the implementation of the strategy. The first round of supervision was conducted by the central level of the Ministry of Public Health and Fight against AIDS, and the second round was conducted by the health district offices. It was noted that some health care providers do not apply the new approach learned immediately after the training. Hunger is a recurrent issue, which makes education on nutrition challenging. Referral of severe malnutrition is challenging because of a low coverage of nutrition services in health facilities.

Trend of number/percent of children who received PENTAVALENT3 against the LOP mandatory result

As shown by the chart below, the immunization targets were reached in Y1-3. In Y4, the malaria epidemic hindered preventive services demand and the number of children receiving immunization services dropped.

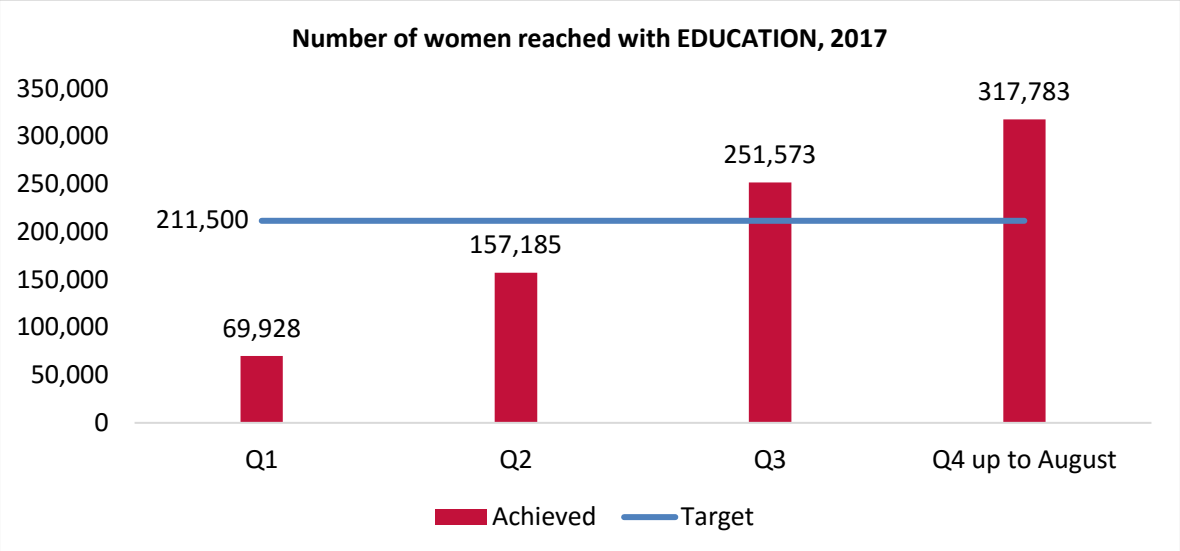
Figure 39:percent of children who received PENTAVALENT3



2.0.6 Number/percent of women reached with education on exclusive breastfeeding

From information gathered from CHWs' monthly reports, the project noted that up to August 2017 288,335 women were reached with education on exclusive breastfeeding, representing 136% of the annual target.

Figure 40: Number/percent of women reached with education on exclusive breastfeeding



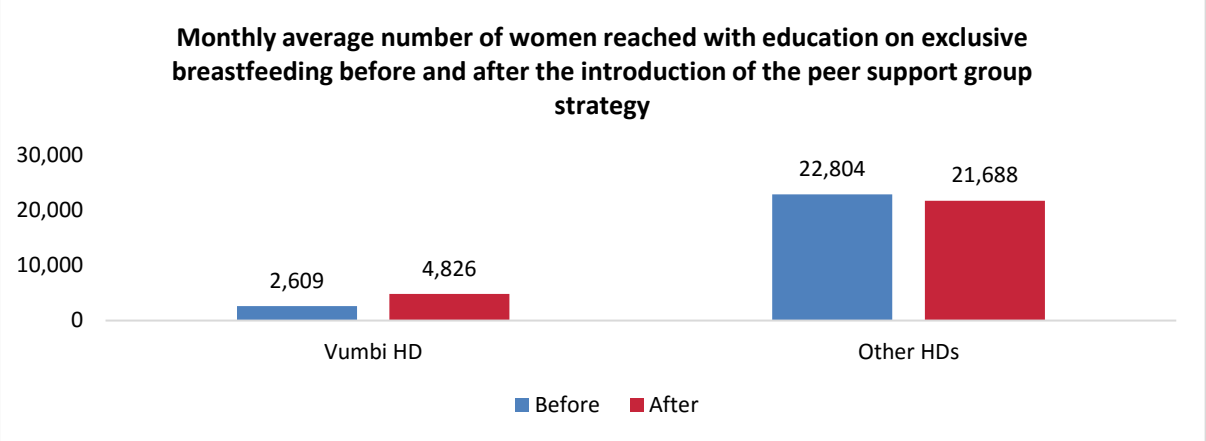
Activities that contributed to achieving the results are as follows:

Improvement of the community health information system
Community data were regularly collected in 9 health districts out of 12 IHPB-health districts of. During year 4, the 3 remaining health districts (Kirundo, Busoni, and Mukenke) were covered by training CHWs on the use of the reporting forms, regular monthly reports collection, and data analysis.

Training of CHWs from Kirundo and Mukenke health districts on the promotion of exclusive breastfeeding
431 CHWs from Kirundo and Mukenke health districts were trained on the 7 key best practices in child health including the promotion of the exclusive breastfeeding. The training of Kirundo and Mukenke completed the coverage of nutrition services provision at community level in the 12 IHPB health districts.

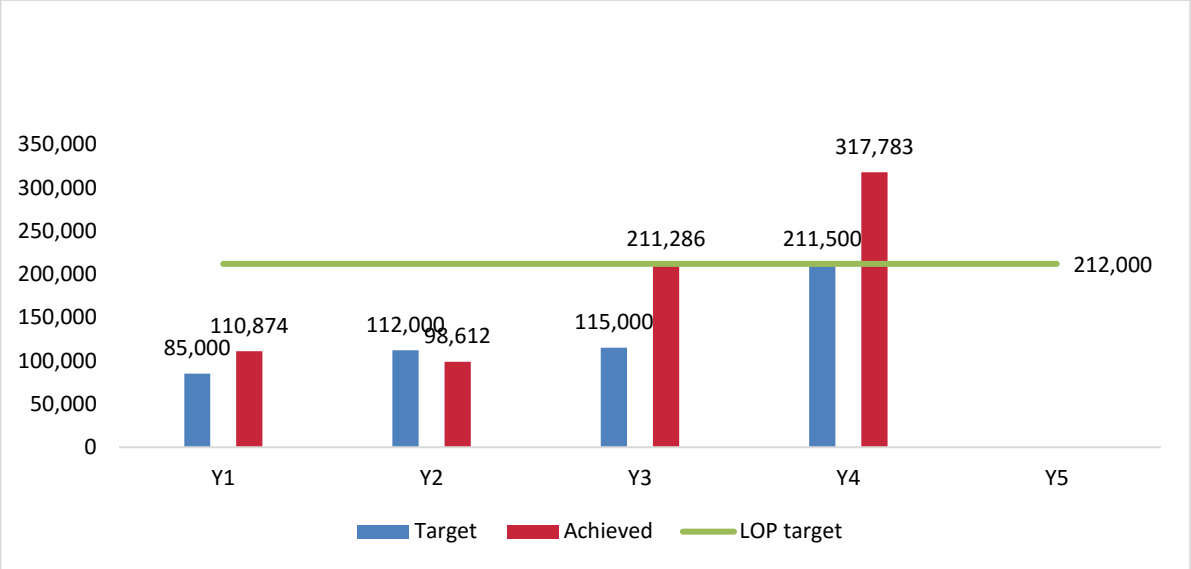
CHW's peer supervision strategy
The strategy consists in organizing CHWs in small support groups at the colline level, headed by a support group coordinator. The CHWs work as a network, organize joint activities, and conduct a peer-supervisory visit to one of them. This strategy has been implemented in Vumbi health district since March 2017 and helped to improve CHWs motivation, credibility, and performance. Vumbi health district saw a significant increase in the number of women reached by the education on exclusive breastfeeding. In effect, Vumbi health district's monthly achievement was on average 2,609 women per month and 4,826 women per month respectively for the period from October 2016 to February 2017 (before the strategy was introduced), and for the period from March 2017 to August 2017. This meant that when the strategy was implemented, Vumbi health district reached about 2 times more women with education on exclusive breastfeeding than before. In 9 other health districts that reported on the indicator, the monthly average was respectively 22,804 and 21,688 for the period from October 2016 to February 2017 and the period from March 2017 to August 2017.

Figure 41: Monthly average number of women reached with education on exclusive breastfeeding before and after the introduction of the peer support group strategy



General trend of results against the LOP mandatory result:
For the indicator number of women reached with education on exclusive breastfeeding, the target was achieved each year, except in Y2 due to new reporting processes. By Y3, IHPB had achieved the LOP target; this was due to the fact that IHPB extended the area of exclusive breastfeeding promotion from 2 provinces (Kayanza and Muyinga) in Y2 to 4 provinces in Y3.

Figure 42: General trend of results against the LOP



Y4 Progress and Discussion on Innovation Studies

After receiving approval from USAID for the innovation plan in Y1, the *Pilot of Integration of Prevention of Mother-to-Child Transmission (PMTCT) and Early Infant Diagnosis (EID) of HIV into Routine Newborn and Child Health Care* protocol and appendices were approved by FHI 360's Institutional Review Board and the Burundi National Ethics Committee, and a statistical visa was granted from the Ministry of Finance and Development Planning and the Institute of Statistics and Economic Studies of Burundi (ISTEEBU).

A Technical Advisory Group (TAG) was appointed by the MPHFA in Y3, and IHPB started a seven-month enrollment period (November 1, 2016 - May 30, 2017) during Y4. Sixty-six HIV-positive mother/HEI pairs were enrolled across 14 target health centers. Prior to study participant's enrollment, data collection forms were pre-tested for two weeks, a study-specific database was developed and health providers from the intervention district were trained on the protocol and ethics provisions. To ensure that the innovation study was and continues to be implemented as detailed in the protocol, three quarterly TAG meetings and three field-based stakeholder meetings were held. In addition, joint supervision and data collection visits were conducted monthly.

Y4 Progress on Communication, Documentation and Dissemination

IHPB Y4 presented important opportunities to share the substantial volume of knowledge generated across project activities, for the benefit of local partners and institutions and international health and development disciplines more broadly. In addition to participating in the organization of the Collaborative, Learning and Adapting (CLA), IHPB Y4 key achievements included documentation of program achievements and learning in select topics:

- Three issues of IHPB News and 9 success stories were published.

Table 21: Number documents published

Type	Number	Title of document
Success stories	1	Reaching the positives among the general population: successful experience of Integrated Health Project in Burundi
	2	Life of 3 triplets saved thanks to IHPB donated incubators
	3	Increase in numbers of people adopting vasectomy in IHPB intervention zone
	2	Men`s involvement and investment celebrated as good examples for health of families
	1	Successes in iCCM implementation of acute malnutrition at community level
Newsletters	2	Reproductive health and family planning awareness vie interactive theater
	1	Supporting service integration with a quality improvement model and preparing health district to scale up best practices
	1	Accroitre la capacité des organisations de la société civile pour optimiser leur capacité à collecter les fonds et améliorer des vies.

- Three technical briefs were published on Malaria, Vasectomy and IHPB experience with uterotonics.
- Three conference abstracts were submitted – two for poster presentation and one for oral presentation. Titled "*Reaching the Positives from the General Population: Experience of Integrated Health Project in Burundi*", was accepted for poster presentation at the International Conference in HIV/AIDS and STIs in Africa (December 4-9, 2017). Entitled "*The Integrated Health Project in Burundi- Development and application of an interoperable health workforce training database*", was accepted for poster presentation for Human Resources for Health Forum in Dublin (November 13-17). The third, titled, "*Use of the Quality Improvement (QI) Collaborative model to Increase Family Planning (FP) uptake in Karusi Province, Burundi*" was accepted for presentation during the 2017 Uganda National Conference on Quality Improvement (August 29-31, 2017).

Y4 Progress on Program Monitoring and Evaluation

During the Y4 under review, IHPB conducted activities to improve and maintain the monitoring and evaluation of the project progress. At inception of Q1, the mid-term assessment was conducted to inform mid-term progress in 45 health facilities (36 HCs and none district hospitals). Findings as compared to baseline showed mid-term progress with 5 indicators: (a) 2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support increased from 15% to 36%; (b) 2.2.1 Percent of supported facilities that provide a core/expanded package of quality integrated health services progressed from 32% to 56%; (c) 2.3.3 Percent of trained health care staff who report positive attitudes about work and the workplace increased from 57% to 79%; (d) 3.1.2 Percent of supported health centers that have available all the necessary materials and equipment to provide services increased from 27% to 51%; (e) 3.2.2 Percent districts and facilities that demonstrably use facility- and community-level data for timely decision making progressed from 87% to 93%.

Three indicators experienced regression: (h) 2.0.1 Couple years of protection rate for family planning from 186,249 to 132,567; (i) 2.1.4 Percent of COSAs that meet defined functionality standards from 68% to 61%; (j) 2.2.4 Percent of supported facilities that receive supportive supervision on a regular basis from 94% to 68%.

During the period under review, IHPB also completed the update of HHS protocol and data collection form (questionnaire), the informed consent forms and other related tools. After FHI 360 Scientific Affairs review, the tools will be submitted soon to the Protection of Human Subjects Committee of FHI 360.

As part of its capacity building plan for IHPB technical and M&E staff and district cadres, IHPB conducted a training of 23 individuals (20 males and 3 females), IHPB (18) and MPHFA staff (5) on basic research methods, epidemiology, and biostatistics, which aimed to provide sufficient skills for better documentation of the project results. The 4 -day training was facilitated by two FHI 360 HQ experts, an epidemiologist and a biostatistician.

IHPB conducted anotherthree-day training on the District Health Information Software 2nd version (DHIS2) and on the use of a project-developed database for the monitoring of the performance of health facilities. DHIS2 is the national open source web-based platform which allows data entry, data validation, data analysis and visualization and storage of aggregated data, data sharing, retro-information and data dissemination. The training was attended by 24 IHPB staff (21 males and 3 females). This application is important because it allows PTOs, M&E officers and Field Office Managers (FOMs) to access and extract the data they need to analyze and document facility performance.

Given that IHPB staff is using data from various sources (DHIS2, DATIM, Training, iCCM, AMTSL, data collect), the project conducted a four-day training on data analysis and visualization using Power BI to address limited access and use of data. Power BI is an analytical data platform that allows interactive data visualization and report generation from the various templates. The training, attended by 23 IHPB staff (19 males and 4 females) was co-facilitated by two FHI 360 HQ staff, a Technical Advisor for M&E/SI and a Research Associate in Geographical Information System.

Based on lessons learned during the baseline surveys, data collection using electronic forms presents many advantages, especially saving time with quick data collection, eliminating the need for separate data entry at an office, and providing more security of the information as the data are transmitted to the server in real time.

Thus, to better prepare the technical staff to conduct these end-of-project studies and successfully take advantage of the project tablets during supervisions, IHPB successfully conducted four-day training on the use of “ODK collect/aggregate/build”. The training included forms design using XLSForms, XML conversion, loading forms to ODK Aggregate, deploying forms to mobile devices, basic data visualization using “Aggregate”, data transfer mechanisms with emphasis to “Briefcase”, and localizing forms to different languages. The training was facilitated by the FHI 360 TechLab Program Director, Berhane Gebru; 19 participants (18 male and one female) attended the training including M&E staff (7), QI Officers (3), PTOs (3), and HSS team members (3).

Challenges and Lessons Learned

In Y4, IHPB registered solid progress, often exceeding Y4 targets. This is attributable, in large part, to the excellent working relationship with the central and peripheral structures of MPHFA and the strong support IHPB received from the various short term technical assistances from the respective headquarters of FHI 360 and Pathfinder International. While the Burundi health care system continues to suffer from inadequate infrastructure (dilapidated buildings; no incinerators, water and electricity; etc.), lack of human resources (high turnover; low motivation; etc.), and lack of basic equipment (microscopes; computers; etc.), table below presents key challenges and lessons learned in Y4:

Table 22: Y4 Learned Lessons and Challenges

Sub-CLIN/Health Domain	Lesson Learned	Challenge
Sub-CLIN 1.1	Despite their low literacy level, following training offered by the IHPB, CHWs rapidly acquired skills in interpersonal communication including conducting home visits and community sensitization activities.	Absence of inter-sectorial communication between the MPHFA and Ministry of Education did not allow IHPB to use the "Le monde commence par moi" module and equip young adult and adolescents with skills that will help promote sexual and reproductive health and HIV/AIDS healthy behaviors.
Sub-CLIN 1.2	Trainings on quantification followed by supportive supervision have contributed to the reduction of stock outs	Continued availability and supply of commodities from the central to peripheral levels
Sub-CLIN 1.3a	The Men as Partner (MAP) approach has been shown to be promising for involving men as decision makers in promoting gender mainstreaming and combatting SGBV.	Male norms and behaviors are rooted in Burundian tradition and culture and to overcome them is a long-term job.
Sub-CLIN 1.3b	The inter-sectorial committees initiated by the IHPB have served and a basis for coordinating interventions for the comprehensive care of survivors of GBV.	The lack of harmonized care tools and a clear referral path to various services make it difficult to collect data on survivors who benefitted from comprehensive care.
Sub-CLIN 2.1	Organizing CHWs in small peer-support groups increased their effectiveness, their motivation, and their credibility.	Women do not trust CHWs for maternity services i.e. accompany them to the health center for delivery and education on safe maternity.
Sub-CLIN 2.2	Integration of FP services improve long last FP methods uptake and contributed to significant increasing of FP contraceptive coverage	Stock out of commodities affected integration
Sub-CLIN 2.3	OASIS is an important tool accepted and owned by the MPHFA.	: The nonsystematic use of post training follows up tools
Sub-CLIN 3.1	Merger of data analysis and coordination meetings allows districts to use data and make evidence-based decisions	Planning and coordination activities will be limited following insufficient financial resources
Sub-CLIN 3.2	Technical assistance and coaching of health facilities to develop data visualization dashboards foster data use	Availability of HIS/MIS registers and tools
Sub-CLIN 3.3	Partnership with SWAA and RBP+ increases demand for HIV screening and treatment	In Y4, USAID did not authorize renewal of partnership with the two CSOs
HIV/AIDS	Testing strategies which targeted high risk populations gave better yield	Recurrent viral load machine breakdowns
Malaria	Outreach mobile strategies should be included in health district work plans and implemented before an outbreak of malaria	Low involvement of administrative leaders in malaria prevention
RH/FP	Willingness by men and women to perform vasectomy and tubal ligation respectively	Unmet needs to male (vasectomy) and female sterilization (tubal ligation)
MNH	Competency-based trainings conducted by IHPB according to national guidelines have improved skills and knowledge of health workers	Frequent staff turnover
Child Health	CHWs play important roles in increasing immunization coverage	Absence of nutrition services in most health facilities

Project Management

In Y4, IHPB, USAID commissioned a mid-term evaluation that was implemented by the consultancy firm Global Health Program. In addition, an external financial review commissioned by USAID and covering the period of January to December 2016 was conducted. The review was conducted by KPMG and the final report was submitted to USAID. It is important to note that as we are submitting this annual report, IHPB has slowed down activities implementation while expecting the next incremental fund for the year 5.

ANNEX: IHPB Indicators – Achievements for the period October 1, 2016 – September 30, 2017

Indicators No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct 2016-Sept 2017)			Y5 Target	EOP Target
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	% Achieved		
1.1.4	Number of health communication materials developed, field tested, and disseminated for use	Annually	N/A	2	0	8	1	4	21	8	8	100%	0	30
1.2.1 [MR]	Percent of supported facilities that experienced a stock-out at any point during the last three months	Quarterly	62%		87%		61%	65%	57%	50%[28]	53% (98/184)	93.5%	45%	52%
1.2.2	Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide [FP/RH 3.1.7.1-2]	Quarterly	37.6%	NA	38%	30%	0%	20%	14%	10%[29]	26% (40/155)	58%	22%	35%
1.2.3	Percent of health centers that meet minimum standards in supply chain management	Annually	49%		49%		88%	87%	87%	87%	99% (166/167)	199%	90%	90%
1.3.1 [MR]	Number of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalances within the household)	Annually	0	0	0	2	0	4	3	5	12	240%	5	16
1.3.2 [MR]	Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products	Annually	0	0	0	0	0	1	0	33% (4/12)	16.7% (2/12)	50%	33.3%	50% (6/12)
1.3.4 (GEND_ GBV)	Number of persons receiving postGBV care (Post-rape care, other post-GBV care, PEP)	Quarterly	102	150	108	150	252	150	117	170	143	84%	339	860
1.3.5	Number of facilities that provide PEP to GBV survivors	Quarterly	7	7	7	14	36	27[30]	26	34	40	118%	34	34
2.0.1 [MR]	Couple years of protection rate for family planning (3.1.7.1-1)	Annually	186,249		134,330	130,313	90,870[28]	136,828	132,567	150,511	207,162	138%	195561	195,561
2.0.3 [MR]	Number of individuals who were referred to and received other health and non-health services	Quarterly	7137		7262		18068	18200	20464	20500	22,467	110%	20,500	73474

[28] Performance will depend to availability of drugs at CAMEBU

[29] Performance will depend on availability of contraceptives at the central level

[30] Target is lower than achievement because PEPFAR support moved from four Provinces to two

Indicators No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct 2016-Sept 2017)			Y5 Target	EOP Target
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	% Achieved		
2.0.4	Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs [3.1.6-61]	Quarterly	81.9%	82%	83%	83.7%	96%	85%	97%	85.7%	94.8% 82,166/ 86,669	111%	95%	+ 5% (86.9%)
2.0.5	Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs [3.1.664]	Quarterly	8.8%	1000	8.8%	7765	15.6%	18%	77%	80%	90.3% 73,100/ 80,924	113%	95%	+10% (87%)
2.0.6	Number/percent of women reached with education on exclusive breastfeeding	Quarterly	N/A	85000	110874	112000	88% (98612)	1150000	211286	211500	335,926	159%	265000	+10% (121,961)
2.0.7 [MR]	Number and percent of pregnant women with known status (PEPFAR PMTCT_STAT_DSD)	Quarterly	94% (127,306/ 135626)	95%	91%	95%	87%	95%	89%	95%	88.4% 49,548/ 56,079	93%	95%	95%
2.0.8 [MR]	Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-childtransmission (MTCT) during pregnancy and delivery (PEPFAR PMTCT_ARV_DSD)	Quarterly	93%	95%	89%	95%	83%	95%	93%	95%	94.0% 756/804	99%	95%	95%
2.0.9	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results (PEPFAR [HTC_TST_DSD]	Quarterly	360446	357023	300475	367842	447365	138048[29]	321944	138048	313,053	227%	116,411	1,139,009
2.0.10	Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR [CARE_CURR_DSD]	Quarterly	10071	10071	12539	13244	12826	8435[4]	8,033	9,195	8,591	93%	12,220	13,000
2.0.11	Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]	Quarterly	12.8%	20%	14.5%	30%	43%	50%	62%	70%[31]	77% (6,619/ 8,591)	110%	95%	95%
2.0.12	Percent of infants born to HIVpositive women that receive a virological HIV test within 12 months of birth (PEPFAR PMTCT_EID)	Quarterly	31%	40%	12%	50%	0	61%	45%	70%	100.7%% 810/804	144%	95%	95%
2.0.13	Number of adults and children receiving ART (TA only) [PEPFAR	Quarterly	4996	6500	6025	7000	6510	7200	6211	9195[32]	8,329	91%	12200	83%

[31] Reduced from 80% to 70% based Y3 achievement

[32] Target set in COP 2016

Indicators No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct 2016-Sept 2017)			Y5 Target	EOP Target
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	% Achieved		
	TX_CURR_TA]													
2.0.14	Proportion of women attending antenatal clinics who receive IPTp2 under direct observation of a health worker[33]	Quarterly	0	-	0	50%	71%	60%	68%	80%	85.0% 72,421/ 85,232	106%	90%	95%
2.0.15	Proportion of pregnant women attending ANC who received ITNs	Quarterly	80.3% (116160/144739)	80%	82 %	92%	79%	94%	81%	95%	71.1% 75,869/ 106,714	75%	95%	95%
2.0.16	Proportion of children under five with fever who received ACT within 24 hours of onset of fever	Quarterly	66.6% (20666/ 31060)		75.9% (44,002/ 58,011)	75%	70.5 % (61.454/ 87,206)	75%	73.8% (102,715/ 139,111)	85%	76.6% 166,498/ 217,237	90%	90%	90%
2.1.2 [MR]	Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)	Quarterly	N/A				86,350	62,000	139,663	63,000	216,739	271%	216,000	419,000
2.1.3	Percent of health centers that have functional CHW systems	Annually	11%				11%	15.9%	75.3%	25.3%	65.3% (109/167)	258%	31%	31%
2.2.2	Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services [PEPFAR FPINT_STE]	Quarterly	26% (45/173)		37.0% 64/173		59.0% 102/173)		74% (71/96)	75%	82.5% (80/97)	110%	83%	83%
2.2.3[MR]	Percent of supported facilities that perform to national technical and quality standards	Annually	75%			50%	56.2%	60%	56.2%	75%	85.1%	113%	90%	90%
2.2.4[MR]	Percent of supported facilities that receive supportive supervision on a regular basis	Annually	94.5%	100%	95.1%	100%	72%	100%	76.6%	100%	70% 128/184	70%	100%	100%
2.3.1 [MR]	Percent of project-trained health providers, managers and CHWs who perform to a defined standard post-training					94%	93%	95%	91%	95%	94.8%	100%	95%	95%
2.3.2 [MR]	Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training	Quarterly	N/A		89%			90%		90%	91.4%	102%	95%	95%
2.3.5	Number of health care workers who successfully completed an in-service training program	Quarterly	N/A			2,100	2,100	1940	1,832	1,336	1,067	80%	1424	6800

[33] Assuming that SP would be available

Indicators No	Indicator	Reporting Frequency	Baseline	Year 1		Year 2		Year 3		Year 4 (Oct 2016-Sept 2017)			Y5 Target	EOP Target
				Target	Actual	Target	Actual	Target	Actual	Target	Actual	% Achieved		
2.3.6	Number of community health/para-social workers who successfully completed a preservice training program	Quarterly	N/A			394	394	1,436	1,444	7,151	10,328	144%	4344	13325
3.0.1[MR]	Percent of supported districts and/or communities with demonstrable links to/leveraging resources from non-USAID sources	Annually								60%	58%	97%	60%	60%
3.1.1[MR]	Percent of supported facilities that have available all current national health policies, protocols, and guide lines	Annually								46%	50%	110%	57%	57%
3.1.2[MR]	Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services	Annually	26.6%	26.6%		28.6%		29.6%	51%	51%	51%	100%	60%	60%
3.1.3	Percent of supported facilities that have the capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	Annually	66.7% (6/9)		66.7% (6/9)		77.8% (7/9)	80% (4/5)	80% (4/5)	100% (5/5)	100%	100%	100%	100)
3.1.4 [MR	Number of PBF indicators supported by the project	Annually		7	7	7	7	NA	NA	NA	NA	NA	NA	7
3.1.5 [MR]	Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis	Annually	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100% (12/12)	100%	100%
3.2.1 [MR]	Percent of facilities that maintain timely reporting	Quarterly	95.4% (165/173		95.4% (165/173)	96.8%	93.6% (162/173)	97.8%	100% (173/173)	97.8%	88.2% (121/184)	90%	100%	100%
3.2.2 [MR]	Percent districts and facilities that demonstrably use facility- and community-level data for timely decision making [MR]	Annually	87%					90%	93%	95%	94%	99%	97%	97%